

Technical Note No. 39

**A PROPOSED FEE STRUCTURE AND PRICES
FOR A NATIONAL PROGRAM
OF COST RECOVERY FOR HEALTH SERVICES
IN THE CENTRAL AFRICAN REPUBLIC**

Submitted to

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by

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HEALTH FINANCING AND SUSTAINABILITY (HFS) PROJECT

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ABSTRACT

This study describes a proposed fee structure and fee prices for inpatient and outpatient health services and medicines for a nationwide cost-recovery program in the Central African Republic (CAR). The study was prepared at the request of the Ministry of Health and Population (MOH). The analysis of alternative fee options focuses on their impact on household income and on what activities and improvements could be funded from their revenues.

The proposed fee structure would require patients to pay a flat daily fee for inpatient services, depending on the type of accommodation, eliminating with two exceptions (minor outpatient surgery and childbirth), separate fees for medical procedures. It would introduce a fee for outpatient consultations and for medicines. The study recommends that fee revenues be retained by the health facilities and that the MOH require that they be used to 1) resupply medicines and support the medicine distribution and stock system, and 2) to pay for quality improvements.

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ACRONYMS

CFAF	Communauté Financière Africaine (CFA) franc
CAR	Central African Republic
CNHUB	University Hospital of Bangui
EPI	Expanded Program on Immunization
HFS	Health Financing and Sustainability Project
MOH	Ministry of Health and Population
PDSS	Ministry of Health Five Year Development Plan
STDs	Sexually transmitted diseases
TSS	Nurse practitioner
USAID	U.S. Agency for International Development

ACKNOWLEDGMENTS

The proposed fee and price structure in this study is the product of the work of many people on health financing policy development in the Central African Republic (CAR) during the course of the Health Financing and Sustainability (HFS) Project. Dr. Charlotte Leighton, senior health economist at Abt Associates, is the principal author of the study and directed the supporting analyses. The medicine pricing structure was developed by Mr. Yann Derriennic, a consultant to HFS in health finance and management, who with Dr. Mark Wenner, an economist at Abt, calculated and estimated the revenues and household impact. Mr. Greg Becker, an advisor to HFS in hospital administration, assisted in the analysis of the current hospital fee system. Dr. Marty Makinen, HFS Technical Director, contributed to the overall design of the fee structure. Numerous officials of the CAR Ministry of Health and Population (MOH) who had designed aspects of cost recovery that were already in place contributed ideas that are incorporated in the study.

FOREWORD

This study is one in a series of reports conducted by the Health Financing and Sustainability (HFS) Project. HFS is a five-year initiative funded by the U.S. Agency for International Development (USAID). The project's mandate is to provide technical assistance, conduct applied research, implement training, and disseminate information on health care financing throughout the developing world. The project seeks to influence policy change by advancing knowledge; testing and improving delivery, financing, and administrative methods; strengthening institutional capacity; and enhancing technical capabilities. To date, HFS has been involved in health care financing activities in over 30 developing countries around the world.

The HFS Project has provided short- and long-term technical assistance to the Ministry of Health and Population (MOH) of the Central African Republic (CAR) since 1990 to develop and conduct related analyses of a national policy of cost recovery for health services. During an HFS mission to the CAR in November and December 1993, the MOH asked HFS to propose a comprehensive fee structure and prices for outpatient and inpatient care to be applied by MOH health facilities nationwide. Resolving policy issues related to the fee structure and prices was the final step needed to develop the implementing regulations for the 1989 law establishing a national policy of cost recovery for government health services.

To provide assistance with these final regulation issues, HFS sent a team to the capital city of Bangui to prepare and participate in a workshop to make decisions about the fee structure and related implementation policies. Appendix B contains a summary of the proceedings of this workshop, which was held April 5-9, 1994, including the debate, decisions made about the proposal, and final modifications made to the proposal.

Later in 1994, a Presidential Decree was issued that allowed implementation of the cost recovery policy ultimately developed by the MOH and the MOH developed a set of implementing regulations. Phased implementation of the program is scheduled for 1995. Both the HFS proposal and the MOH proposal (and the respective modifications) are spelled out in Appendix B. The text of the Presidential Decree is included in Appendix C.

EXECUTIVE SUMMARY

In 1993, the Ministry of Health and Population of the Central African Republic (CAR) asked the Health Financing and Sustainability (HFS) Project to develop a proposal for a fee structure and prices for inpatient and outpatient health services and medicines that could be applied in a nationwide program of cost recovery. This document outlines the HFS proposal, summarizes its rationale, and evaluates its potential impact. The study was originally drafted as a background paper for discussion by a small group of MOH experts, who commented on and made revisions to the proposal and then presented it to a larger conference of MOH representatives, as well as to representatives of other government offices and ministries, nongovernmental groups, and international donors.

The MOH established certain principals for cost recovery at a 1989 workshop, which HFS sought to follow in developing this proposal:

- ▲ Equity for different income levels and regions of the country;
- ▲ Access to care (geographic and operational);
- ▲ Resources sufficient to improve quality;
- ▲ Administrative feasibility; and
- ▲ Efficiency.

In addition, the MOH recently emphasized that the fee structure and price levels must represent a balance between 1) the population's ability and willingness to pay and 2) the costs of providing health services. The HFS team therefore focused its analysis of alternative fee options on their impact on household income and on the activities and improvements that could be funded by the revenues generated under each alternative.

Because the government and the MOH have consistently maintained that the government would continue to pay the salaries of health workers, the HFS team did not design this proposal to recover all annual recurrent costs of the governmental health system. Instead, the proposal focuses on recovering only nonsalary recurrent costs, particularly the costs of medicines, essential medical supplies, and quality improvements such as better facility maintenance and improved personnel performance incentives.

THE PROPOSED FEE STRUCTURE

The proposed fee structure covers medicines, outpatient services, and inpatient services. The bulk of this study discusses the advantages of the proposed system, particularly its administrative simplicity, the equity of the plan, and its ability to meet the current goals for cost recovery in the CAR. Here is a summary of its main features:

Medicines

- ▲ Patients pay full cost of all inpatient and outpatient medicines at all levels of the health system.

Outpatient Services

- ▲ Patients pay a pharmacy service fee or consultation fee, depending on the level care.
- ▲ Where minor outpatient surgery is needed, patients pay a fee for outpatient surgery instead of the consultation fee.

Inpatient Services

- ▲ Patients pay a flat daily fee, which varies according to the type of accommodation.
- ▲ Patients also pay an additional fee for child delivery services.

The MOH specifically requested that HFS propose an alternative to the “*lettre clef*” hospital fee structure then in effect under Decret 91.065. The alternative proposed here would eliminate, with two exceptions (minor outpatient surgery and childbirth), the separate fees for medical procedures and would introduce a fee for medicines.

PRICES

The proposal suggests prices for these inpatient and outpatient medicines and services, offering “high-option” fees and “low-option” fees. In general, the prices proposed for services at various levels of the health system are designed to recognize lower and higher levels of specialization among health personnel and between hospitals and health centers in the capital city of Bangui compared with those elsewhere. The proposed prices for medicines vary according to the original cost of each medicine, although prices for each specific medicine would be the same throughout the country. For example, patients would pay the same price for chloroquine at all MOH health facilities, whether it was needed for an inpatient or outpatient illness episode. The proposed medicine prices have been adjusted to take account of the recent devaluation of the CFA franc.

USE OF FEE REVENUE

This proposal recommends that fee revenues be retained by the facilities and that the MOH require that health facilities use fee revenues for two purposes. The top priority is to resupply medicines and to support the medicine distribution and stock system. The balance of revenues should be used to pay for quality improvements in these areas, in order of priority:

- ▲ essential medical supplies and equipment;
- ▲ personnel performance incentives; and
- ▲ other improvements most highly associated with patient perceptions of quality (e.g., transport for mobile vaccination teams, facility maintenance, sending personnel to short training courses).

IMPACT ON HOUSEHOLDS

Data presented here suggest that the proposed fees, under both the high and low options, would be affordable for most of the population, especially for middle- and upper-income households. Only the lowest-income households would have significant difficulty paying these fees — for example, a seven-member family with an annual income of 210,000 CFAF or less, and then *only* if they had one hospital episode, a series of outpatient visits, and a childbirth in a given year. The data analysis in this paper demonstrates that in a given year even the lowest-income households would be able to afford a series of outpatient visits, a childbirth, and the cost of fully immunizing that child.

In fact, the financial impact on the lowest-income households of having both outpatient and inpatient illnesses would be more severe under the current system than under the proposed system. The proposed “low-option” fees would generally result in lower costs for outpatient episodes and the typical inpatient hospital stay than under the current system, especially in the case of surgery and general medicine.

IMPACT ON REVENUE AND QUALITY IMPROVEMENT

Health facilities would receive enough revenue under both the low- and high-option fees to cover all medicine costs and to have funds left to improve service delivery and provide personnel performance bonuses. Under the modest utilization assumptions used here, even the low-option fee would provide revenues for notable improvements compared to the present situation. For example, analysis in this paper shows that even after providing for medicine resupply, revenues under the proposed fees—even under the low-fee option—would exceed the MOH budget allocation to the University Hospital for Bungui for all nonsalary operating costs in 1990, the last year the hospital was fully operational.

One possible exception are health posts that serve small population bases. For these, the low-option fee may not provide adequate funds to make necessary improvements and provide personnel incentives. The paper discusses options for such circumstances.

EXONERATIONS AND SUBSIDIES

On the advice of numerous people interviewed by the HFS team in November and December 1993, this proposal recommends that no additional steps be taken by the MOH to establish a formal system of exoneration. Local communities can continue to take care of indigents informally as needed. The current system of social assistance in cases of extreme need can continue to pay the costs of hospitalization. In all cases, the required fees should be paid to the facility on behalf of the indigent—by the local community, a friend or neighbor, or the local government that provides the social assistance.

After evaluating the proposed system after its first year in operation, the MOH could provide new criteria for cases of “medical indigence,” based on options the work group can discuss. The MOH also should establish a monitoring system to identify whether there is a need for a more formal system of exemption for hospitalizations.

This proposal recommends that the current subsidy for civil servants be eliminated or reduced because this group is among those most able to pay for health care. The data analysis in this paper shows that this group is able to pay not only for outpatient services and medicines, but also for hospitalizations, especially since such events do not occur every year. In addition, funds saved by reducing this subsidy could be used to provide assistance to indigents.

IMPLEMENTATION PLAN

Several important implementation issues are raised by this proposal, including 1) the paramount need to have a system in place for the purchase and distribution of medicine when the new cost recovery system is introduced, 2) the need to establish a means of identifying the costs of desired quality improvements in health facilities, 3) future plans for a limited system of exoneration, 4) a system for monitoring the impact of the cost recovery system, and 5) the need to pay the salaries of health workers regularly. In addition, the work group will need to discuss how to inform health workers and the public about the new system and what training and financial management systems will be needed under the new system.

The work group also will need to discuss how to phase the implementation process and in what areas localities should be given flexibility in implementing the national standards. The phased implementation plan should take into account that the fees adopted at the start of the program can and should be evaluated after the first year and modified as necessary.

1.0 INTRODUCTION

This paper is meant to provide background information for a small work group comprised of officials from the Ministry of Health and Population (MOH) and other government agencies who have experience with efforts to develop a policy of cost recovery for health services in the Central African Republic (CAR). This work group will meet to make recommendations for final regulations to implement a comprehensive plan of nationwide cost recovery for MOH health services. The work group recommendations will cover:

- ▲ a fee structure for all levels of the health care system;
- ▲ prices for each type of fee proposed;
- ▲ the use of revenues collected from fees; and
- ▲ the allocation of the MOH budget.

In addition, the work group will identify the main components of a phased implementation plan for the new program to begin in June 1994. Their recommendations in this area will cover:

- ▲ the actions needed to make the cost recovery policy operational throughout the country; and
- ▲ the government ministries or offices responsible for carrying out the main activities

The work group will make its recommendations to a larger workshop chaired by the minister of health and comprised representatives from the MOH, other government ministries and offices, and international donors. The purpose of the larger meeting will be to discuss the recommendations of the work group and to reach a consensus on a final recommendation for the minister of health.

This paper provides an introductory summary of the proposed fee and price structure, its rationale, and its likely impact. It includes summary data, graphic explanations, and supplemental tables (see Appendix A). More detailed discussions and explanations of the proposal will take place at the workshop.

2.0 BACKGROUND

The team from the Health Financing and Sustainability (HFS) Project has provided short-and long-term technical assistance to the MOH to develop and analyze a national cost recovery policy since 1990. During an HFS mission to the CAR in November and December 1993, the MOH asked HFS to propose a fee and price structure for outpatient and inpatient care to be applied by MOH health facilities nationwide. Senior officials in the MOH wanted to discuss the proposal at a workshop that would reach final decisions about cost recovery and that would be held in advance of a large donor meeting planned for the spring of 1994. Scheduling the workshop this way would enable the MOH to meet requirements set by several donors who were encouraging the MOH to fully implement their cost recovery policy nationwide.

The government of the CAR and the MOH have made many of the fundamental policy decisions about cost recovery for health services. With the enactment of a law in 1989 and through the subsequent issuance of general regulations (*“decrets”*), they have established the principle that the cost of health care would be shared by the government and the population. Under this principle of cost sharing, the government is responsible for paying the salaries of health workers and a portion of the operating costs of health care facilities and the population is responsible for paying the remaining operating costs, especially medicines, through a fee system. In addition, the government has authorized partial financial autonomy for hospitals in Bangui, which can retain the revenues from fees to pay for the operating costs of their facility. Final regulatory action to extend this partial financial autonomy to other health facilities is pending.

In addition, there is consensus that some degree of community participation and involvement will exist in managing the collection of fees and in deciding how to use the revenues from fees. There also is consensus that it will be necessary to institute some system of performance incentives for health workers, paid for with revenues from fees.

Two large reference hospitals in Bangui already are implementing cost recovery under the general authorities of the 1989 law and subsequent *“decrets.”* Outside of Bangui, some MOH facilities already charge various fees for some services or medicines, either within the framework of a “project” or under the general authorities of the 1989 law and *“decrets.”*

The final regulations (*“arretes”*) that would provide specific national guidance for implementing cost recovery nationwide at all levels of the public health system are under consideration by the MOH. These final regulations would provide guidance to all levels of the public health system about what fees to charge for what services and how the fee revenues should be managed and used.

While the MOH has reached a consensus on charging fees for medicines used for outpatient care in health centers and posts outside of Bangui, there is less agreement about whether to charge for outpatient consultations. The current hospital fee structure and price levels for medicines, consultations, inpatient stays, and medical acts and procedures present particular difficulties. The MOH seeks to develop a hospital fee structure and prices that can be justified on the basis of hospital costs and the population’s ability to pay. They also want the hospital fee structure to include performance incentives for personnel

and, if appropriate, to take into account differences between reference hospitals in Bangui and hospitals at the regional and prefectural levels.

The main concerns officials at the MOH have about the proposal under consideration is that it is not based on costs of services; that the proposed prices are not likely to be affordable for the population; and that it may not adequately adjust for patient's income levels.

The top priorities of the MOH for cost recovery therefore are to resolve issues about fee systems and amounts, especially at the hospital level; to issue regulations (*"arretes"*) to institute fees at all levels of the health system; and to begin implementation of the national cost recovery program. The plan the MOH adopted in December 1993 includes a workshop at which decisions will be made about the fee issues and an implementation plan will be developed. The goal is to begin implementation in June 1994.

3.0 CRITERIA FOR COST RECOVERY

The HFS team designed this proposal to meet several criteria that the MOH has established for its national program of cost recovery. During a health financing policy workshop in 1989, the MOH identified several key criteria for a national cost recovery program. The program should promote or ensure:

- ▲ Equity for different income levels and regions of the country;
- ▲ Access to care (geographic and operational);
- ▲ Resources sufficient to improve quality;
- ▲ Administrative feasibility; and
- ▲ Efficiency.

In addition, the MOH recently emphasized that the fee structure and price levels should represent a balance between 1) the population's ability and willingness to pay, and 2) the costs of providing health services. Therefore, the HFS team concentrated on assessing the impact of alternative fee options on household income and on the activities and improvements that could be funded by revenues from each alternative.

It is important to note that because the government and the MOH have consistently maintained that the government would continue to pay the salaries of health workers, this proposal does not consider it a criterion of the cost recovery program to recoup all the annual recurrent costs of the government's health system. Instead, this proposal focuses on recovering only nonsalary recurrent costs, especially the cost of medicines, essential medical supplies, and quality improvements such as better facility maintenance and improved personnel performance incentives.

4.0 PROPOSED FEE STRUCTURE

The proposed fee structure would require that patients pay something for all inpatient and outpatient health services and for medicines at all levels of the health system. *Exhibit 4.1* outlines the proposed system. The proposal includes “high” and “low” options for the specific fee prices for these services and medicines so that the workshop participants and the MOH can assess the impact of alternative fee levels on their goals for cost recovery. Mid-level fees within these ranges also can be easily identified for discussion. *Exhibits A.1 and A.2 in Appendix A* list the high and low fee options. What follows is a brief description of the proposed fee structure and rationale, followed by an assessment of the impact of the high and low fee options.

4.1 MEDICINES

Patients pay the full cost of all inpatient and outpatient medicines at all levels of the health system.

At all levels of the health care system, patients would pay a fee for medicines, including vaccines. The prices will cover the full cost of the system for purchasing and distributing medicines—including the cost to resupply the medicines, customs duties, transportation costs, operating the resupply and stock system—as well as a small margin for the health facility's own use. *Exhibit 4.2* illustrates how these prices would be set, as well as how revenues from sale of medicines would be used to cover resupply costs.

Under this proposal, vaccines would be treated the same as all other pharmaceuticals; patients would pay a fee for vaccines calculated on the same basis as the fees for other medicines. Similarly, fees would be charged for medicines to treat high priority health problems, such as malaria or sexually transmitted diseases (STDs). Recent household surveys in the CAR and elsewhere in Africa have demonstrated the strong willingness of the population to pay for medicines and for immunization.

In the interest of uniformity and simplicity and to accommodate the population's ability to pay, this proposal includes immunization under the category of medicines rather than including a separate fee that would cover a variety of the costs of immunization. The cost of vaccines usually constitutes the smallest share of the cost of immunization and, under this proposal, would represent the minimum amount the government could ask parents to pay for fully immunizing their children. Local communities also could decide to ask parents or the population at large to pay additional amounts, for example, to cover the extra costs of maintaining the cold chain or providing mobile health teams, to the extent that other cost recovery fee revenues do not cover those costs. Alternatively, the MOH could decide to use funds freed up by the cost recovery program to subsidize the immunization effort.

Exhibit 4.1 Proposed Fees: Low Option for Hospitals Outside Bangui and Health Centers (CFAFs)

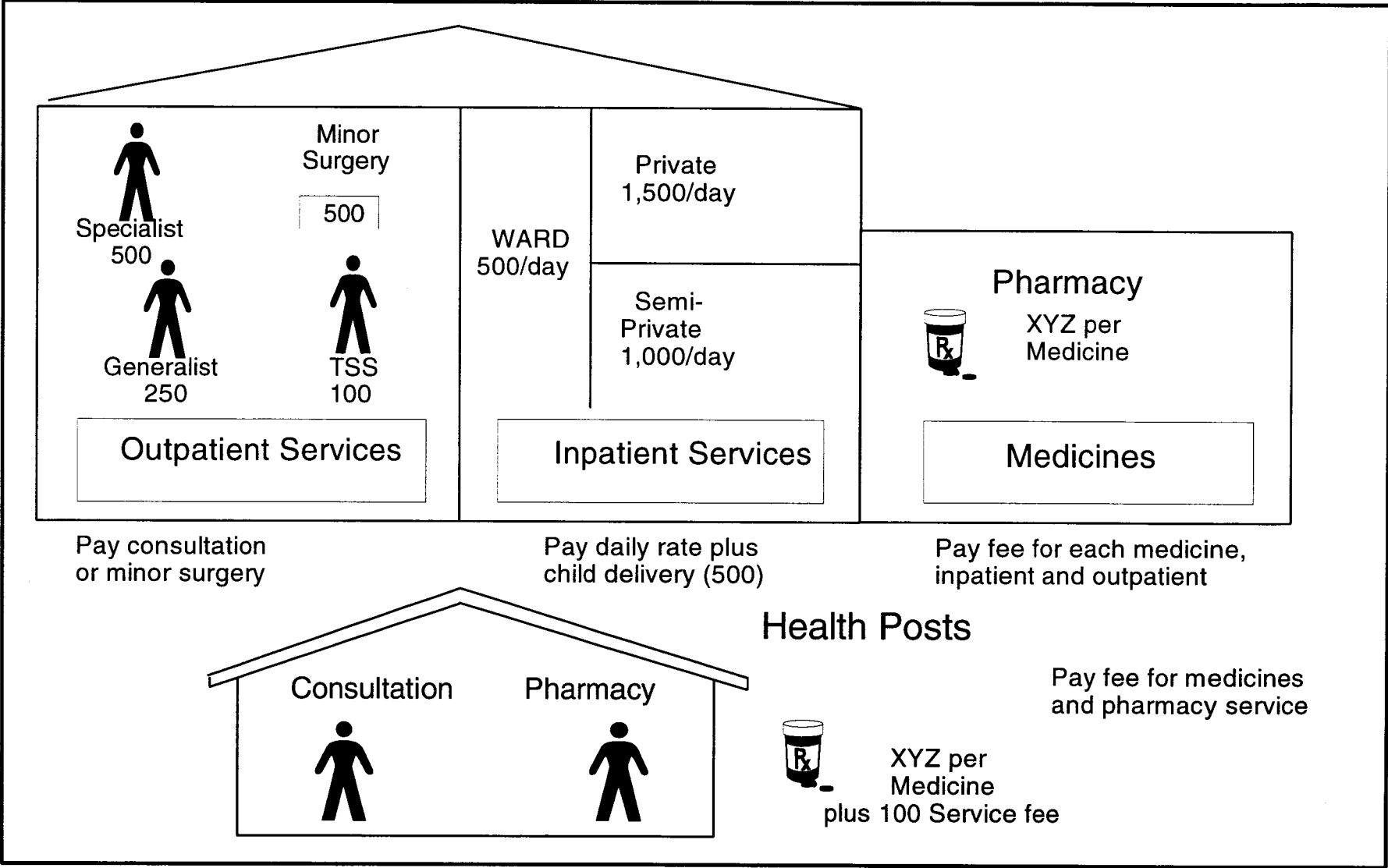
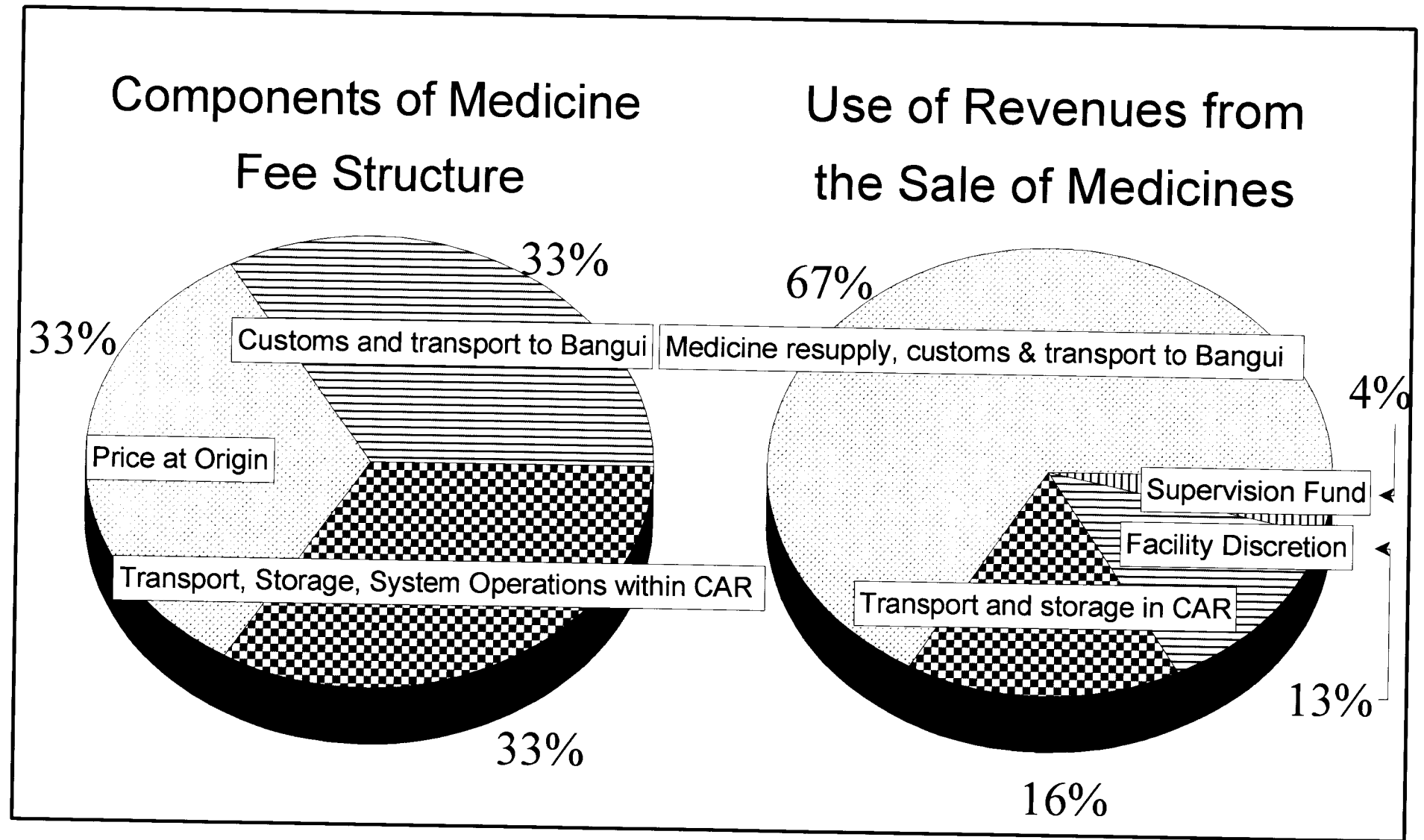


Exhibit 4.2 Components of Medicine Fee Structure and Use of Revenues from the Sale of Medicines



4.2 OUTPATIENT SERVICES

Patients pay a pharmacy service fee or consultation fee, depending on the level care.

Where minor outpatient surgery is needed, patients pay a fee for outpatient surgery instead of the consultation fee.

In addition to paying for medicines, patients would pay a consultation fee at hospitals and health centers where higher-level health personnel are assigned. The consultation fee would be set at three levels, the highest for a specialist or professor, the middle level for a generalist, and the lowest level for a TSS (nurse practitioner). At health facilities without such staff, such as health posts, patients would pay a pharmacy service fee that is equal to the consultation fee for a TSS. The same consultation fees for these types of providers would apply to consultations that result in outpatient care and to diagnoses requiring hospital admission.

If a consultation indicates the need for minor outpatient surgery (including plaster casts), patients would pay an outpatient surgery fee instead of a consultation fee. The outpatient surgery fee would be higher than the consultation fee, in recognition of the additional cost represented by the additional supplies and health personnel of a higher skill level. The payment of an outpatient surgery fee would provide an incentive to health personnel to treat minor surgery on an outpatient basis whenever medically appropriate rather than to admit patients to hospitals.

4.3 INPATIENT SERVICES

Patients pay a flat daily fee, varying according to type of accommodation.

Patients also pay a separate, additional fee for child delivery services.

Patients who are admitted to hospitals or health centers for inpatient care would pay a flat fee for each day they are in the hospital. The daily fee would vary by type of accommodation, with fees for wards being the lowest, semi-private rooms in the middle, and private rooms the highest. No separate fees would be charged for any acts or procedures carried out for an inpatient, except for child delivery.

An additional flat fee would be charged for child delivery to recognize longstanding current practice for this service as a special procedure with a separate charge. Child delivery also is a service for which households can plan and is not an unanticipated event, as are other hospital admissions. Maternity

also represents a sizable share of inpatient care in the CAR. For example, it was the largest single cause of admission at CNHUB in 1990, representing 32 percent of all admissions, compared with 42 percent for a wide range of diagnoses requiring specialty services, 15 percent for general medicine, and 11 percent for surgery.

4.4 GENERAL DISCUSSION AND RATIONALE

There exists a wide variety of payment methods for health care, as well as simple and more complex combinations of such methods, including fees for medicines, fees for consultations, fees for a given episode of illness, fees for consultations plus medicines, fees for individual medical acts and procedures, payment by diagnosis, and prepayment for selected packages of services. There are advantages and disadvantages to each of these methods, many of which are currently in place at health facilities in the CAR.

Under this proposal, only a few methods are used under a simple and uniform national structure. This serves the interests of administrative simplicity, makes it easier for patients to understand, and reduces the amount of monitoring and adjustment the MOH must undertake once the system is in operation.

For example, the same fee structure and the same prices for medicines and services would apply nationwide. The exception is that consultation and inpatient fees at Bangui hospitals would be slightly higher than fees at inpatient facilities outside Bangui, in recognition of the fact that the Bangui hospitals serve as referral centers and that they provide a higher level of care. Under the same principal, fees at all hospitals and health centers outside Bangui would be the same, on the assumption that health centers and hospitals currently do not differ significantly in the quality of service they provide.

The fee structure also is designed to discourage health personnel from providing more services or unneeded services for the purpose of raising revenue or increasing their incomes. In this regard, the proposal depends on continued and regular payment of the salaries of health workers.

5.0 USE OF FEE REVENUE

Under this proposal, fee revenues would be used to cover nonsalary recurrent costs that improve medicine supply, the medical quality of health service delivery, and patient perceptions of quality and access. The MOH should require that health facilities use fee revenues for the following purposes:

- ▲ The top priority is to resupply medicines and to support the system for distributing and stocking medicines.
- ▲ The balance of revenues should be used to pay for quality improvements, in order of priority:
 - △ essential medical supplies and equipment;
 - △ personnel performance incentives; and
 - △ other improvements most highly associated with patient perceptions of quality (e.g., transport for mobile vaccination teams, improved facility maintenance, funds for personnel to attend short training courses).

The HFS team also recommends that the MOH establish specific percentage guidelines for allocating fee revenue, at least in the first year of operation.

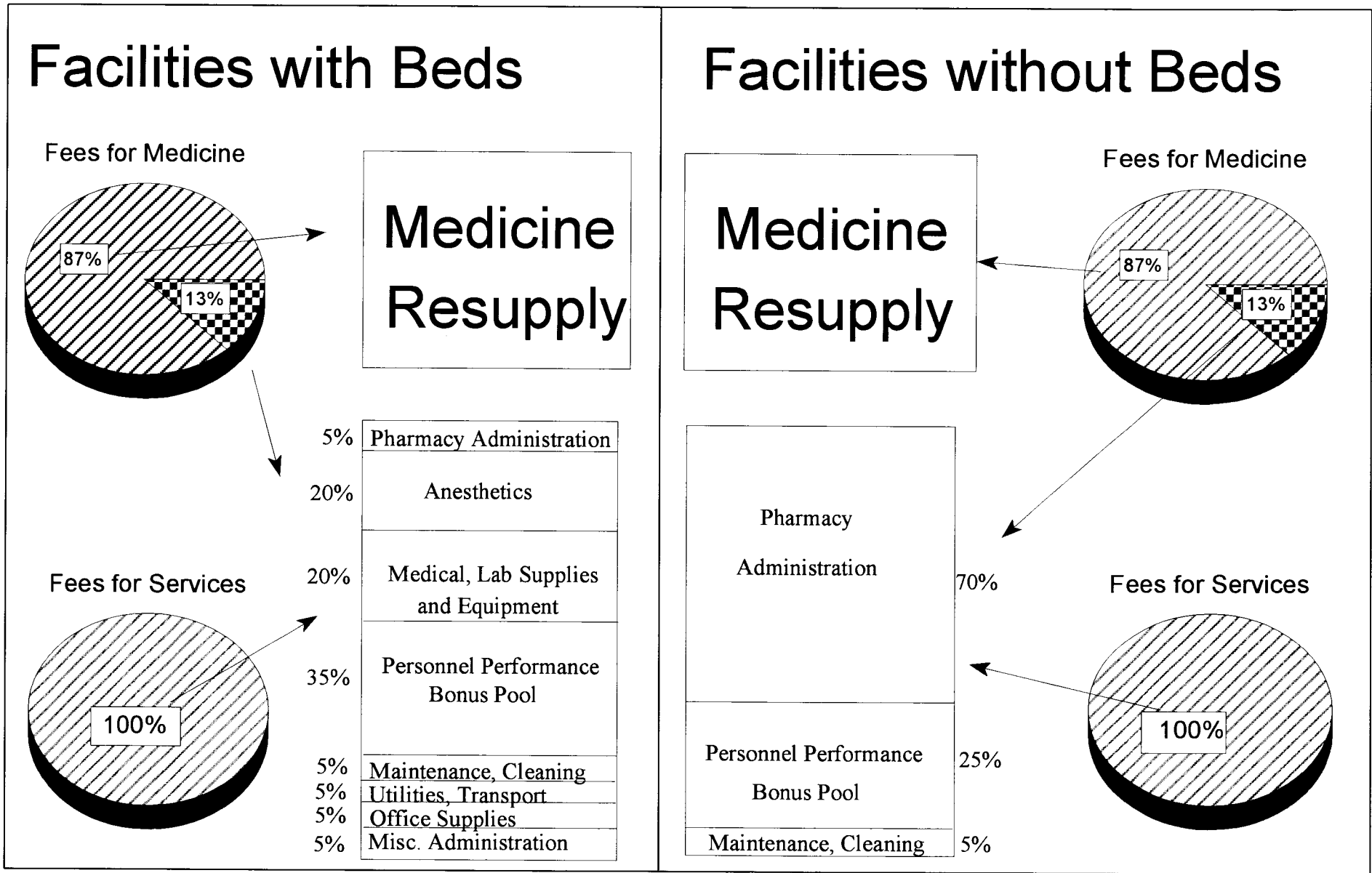
Exhibit 5.1 illustrates how revenues from medicine and service fees could be allocated for these purposes. The illustration uses hypothetical percentages that roughly reflect the share of nonsalary operation costs these activities often represent for health facilities. Data on nonsalary expenditures from one Bangui hospital, Complexe Pediatrique, were used as a guide. One of the most significant items in terms of percentage of operating costs is the use of revenues for a personnel performance bonus pool, which was set at 35 percent to reflect current practice in the CAR.

5.1 GENERAL DISCUSSION AND RATIONALE

Experience with cost recovery in Africa has shown that quality improvement should precede or accompany the introduction of fees. Improving the supply and availability of medicines is generally the first and most important criteria to the general population.

Experience also demonstrates that patient perceptions of quality are often more important than technical measures of health service quality. Numerous surveys and operational experience have demonstrated that the population in the CAR, as well as in other African countries, is willing to pay fees for improved facility appearance and maintenance, for training of health workers to increase their knowledge, for transportation of mobile vaccination teams, and for transportation for purposes of supervising health workers.

Exhibit 5.1 Use of Fee Revenues



Experience in Africa also shows that health workers need incentives to make a new cost recovery system work. To provide these incentives, it is generally necessary that most, if not all, of the fee revenues be retained at the facility level to be used by that facility to improve its services. It also is generally necessary that some of these revenues be used specifically to provide performance incentives to the health workers, especially where salaries are relatively low or are paid irregularly.

One other important use of revenues that should be considered for the CAR is a redistribution of revenues to smaller facilities that serve smaller population bases and which are unable to make the minimum improvements in quality. There could be a requirement that larger facilities with higher revenue-generating potential contribute a small portion of their revenues to a regional or district “solidarity fund” to help these smaller facilities. Alternatively, a subsidy from the MOH could be used for this purpose.

6.0 IMPACT OF THE PROPOSAL

In response to the request from the MOH, the HFS team analyzed the proposed fee structure and prices specifically to assess its impact on the population's willingness and ability to pay for health services and its impact on the relationship of revenues produced to the nonsalary recurrent costs of health services. This section summarizes the findings of this assessment.

6.1 DATA BASES

Data for assessing the impact of the proposed fee structure and prices came from several sources. Data for the population's ability and willingness to pay is based on results from the nationwide household survey that the Health Economics Unit conducted in 1991, as well as information from the Expanded Program on Immunization (EPI) survey conducted in 1993.

Data for estimating health facility costs and revenues included the 1992 Health Economics Unit hospital cost study; 1990 utilization statistics from University Hospital of Bangui and Complexe Pediatrique; and morbidity statistics from the MOH five-year development plan (PDSS). The base year 1990 was chosen for facility cost analysis because it was the most recent year for which relevant data were available and for which the MOH budget authorizations were likely to actually be made available to facilities; it was also a year in which facilities functioned at close to their normal capacity.

For medicine costs, the HFS team used Primary Care Unit 1993 simulations of medicine costs for selected types of illness episodes, as well as verbal estimates from experts in Bangui for selected medicines and for vaccines. The mark-up on medicine costs—which provides for the costs of transportation, operating costs of the resupply and stock system, and facility margins—is based on the normal practices of the cost recovery projects underway in the CAR. The proposal also incorporates the effect of the recent devaluation of the CFAF by doubling the 1993 price at origin of all medicines and vaccines (as valued in CFAF).

6.2 HOUSEHOLD ABILITY AND WILLINGNESS TO PAY

To evaluate the impact of the proposed fees on household willingness and ability to pay, the HFS team developed a profile of typical outpatient illness episodes and two possible types of inpatient care—childbirth and one general medicine hospital stay—that might occur in a seven-member family, which is the average household size according to the national household survey. To evaluate the equity of the impact of the proposed fees, we estimated this impact for households at three income levels: lowest-income households in rural areas, middle-income urban (non-Bangui) households, and high-income Bangui households. (Household incomes for these different levels are based on data from the household survey.)

Exhibits A.3 and A.4 in Appendix A show the annual amounts families would pay for these illness episodes under both the low and high option fees and what percentages of annual household

income this spending would represent. *Exhibits 6.3, 6.4, and 6.5* illustrate this impact graphically and compare the proposed fees with willingness to pay for outpatient health services, as well as with current spending for such services.

6.2.1 Outpatient Illness

Exhibit 6.1 shows the average amounts currently paid by households of different income levels in rural, urban, and Bangui settings for a typical outpatient illness episode, according to the 1992 household survey. These data show that all households spend a significant amount of their income for an outpatient illness, even those in the lowest-income quintile (number 1 in the exhibit). In each of the three geographic settings, spending increased with income—that is, households with higher incomes spent more on health services than lower-income households. Bangui households at all income levels spend somewhat more for an outpatient illness than other urban populations, except for the highest-income group in other cities. Rural households spend the lowest average amounts at all income levels.

Exhibit 6.2 uses data from the household survey for a comparison of the proposed fees, current spending, and willingness to pay for priority medicines and selected quality improvements. As this exhibit shows, for households at all income levels the proposed fees for a single typical outpatient episode are lower than both current spending and the amount the population is willing to pay for both the low and high option fees.

Exhibits A.3 and A.4 in Appendix A show that on an annual basis, total annual fees under the low-option fee for outpatient medicines and services—assuming that each child and adult in the family has one outpatient illness episode—would represent 2 percent of annual income for the lowest-income rural household and less than 1 percent for middle-income urban and high-income Bangui households. Under the high-option fee, annual household spending for outpatient services and medicines would range from 3.6 percent of annual income for lowest-income households to 1 percent for middle-income households, and would be less than 1 percent for high-income Bangui households. These percentages are lower than current estimated annual spending for outpatient care (see *Exhibit A.4 in Appendix A*).

6.2.2 Inpatient Care

Exhibit A.5 in Appendix A compares 1) household costs for a typical hospital stay under the proposed high and low-option fees for a Bangui hospital with 2) costs under the current system in effect under Decret 91.065. As these data show, a patient would pay about half as much for a typical inpatient stay for eight days in a ward room for surgery or other specialized services under the proposed low-option fee than under the current system and about 60 percent as much under the high-option. For general medicine or a normal child delivery, a patient in a ward room would pay about the same under the proposed low-option fee as under the current system and somewhat more under the proposed high option.

Exhibit 6.1 Average Household Expenditure for an Outpatient Illness Episode by Income Quintile and Residence

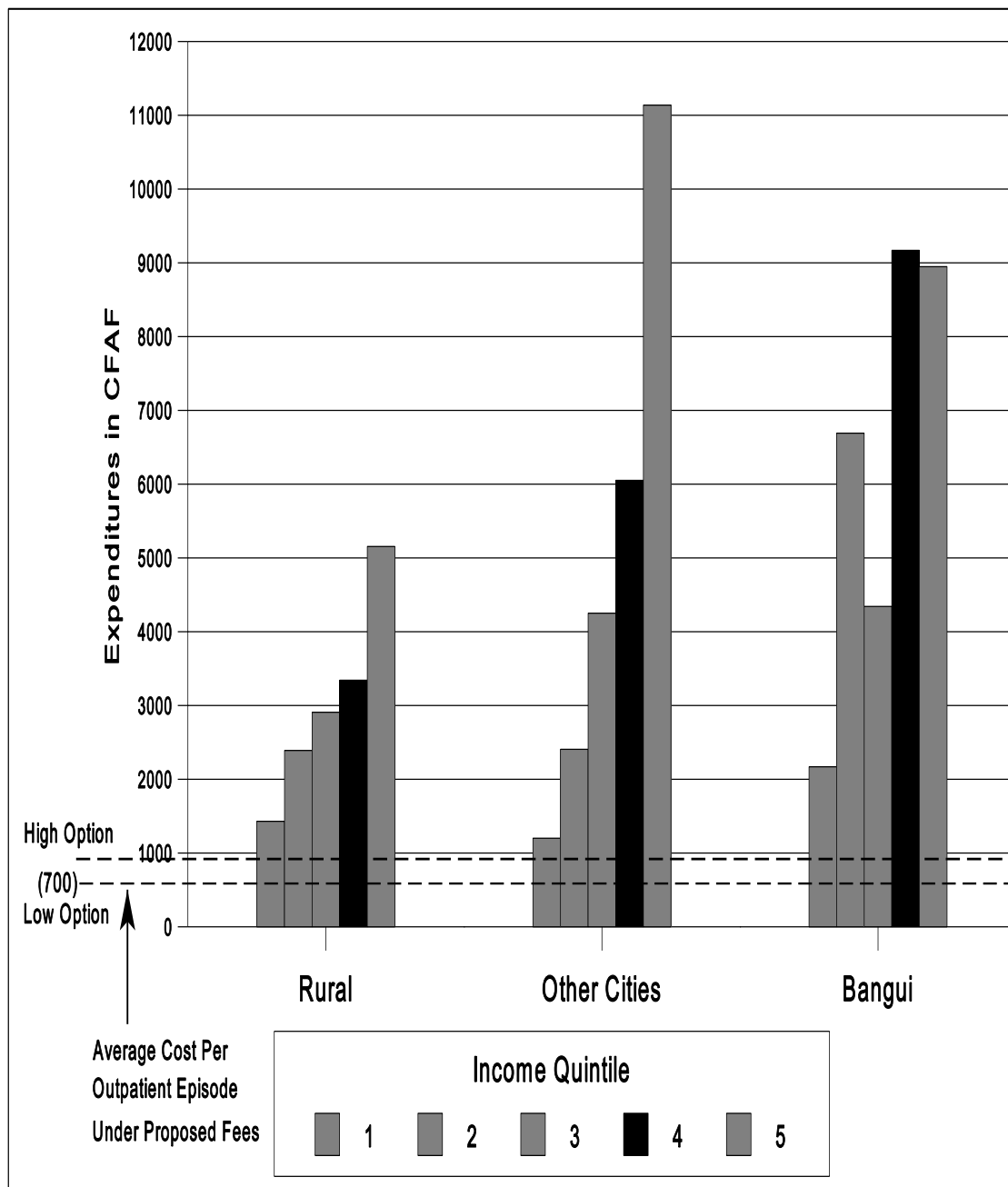
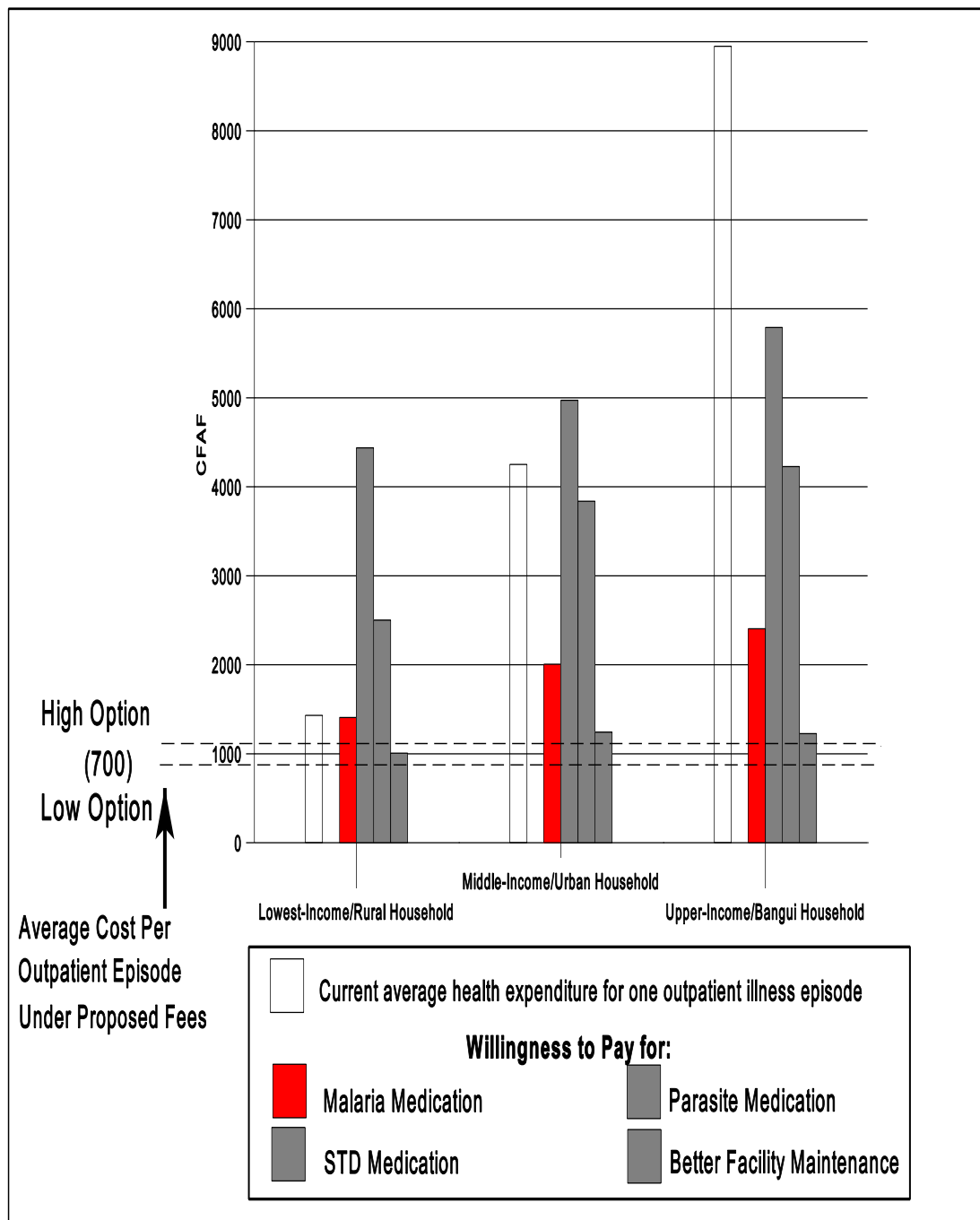


Exhibit 6.2 Current Household Spending and Willingness to Pay for Out-patient Health Services, Medicines, and Quality Improvements



Patients who choose semi-private or private rooms also would generally pay less under both the low and high option fees. In addition, it is likely that the proposed fees would result in costs to patients that were equal or lower than current fees at private mission facilities, based on the 1992 Health Economics Unit analysis of hospital costs and charges.

Under both the current and the proposed fee structure, patients pay less for each day of inpatient care outside Bangui than in the central hospitals. The current structure, however, maintains the same fee for medical acts and procedures whether performed in Bangui or outside. Thus, although the proposed fee structure includes higher fees for a day of inpatient care outside Bangui than the current system, this difference is offset by the additional fees now charged for procedures as required under the current structure.

The net result for inpatient care outside Bangui is that patients would pay an equal or lesser amount for an eight-day hospital stay in all categories of service (surgery, general medicine, maternity) for all three room categories under either of the proposed fee options than they would under the current Decret 91.065 system. One exception to this comparison is that patients might pay more for an inpatient stay for a normal childbirth under the high-fee option than under the current system.

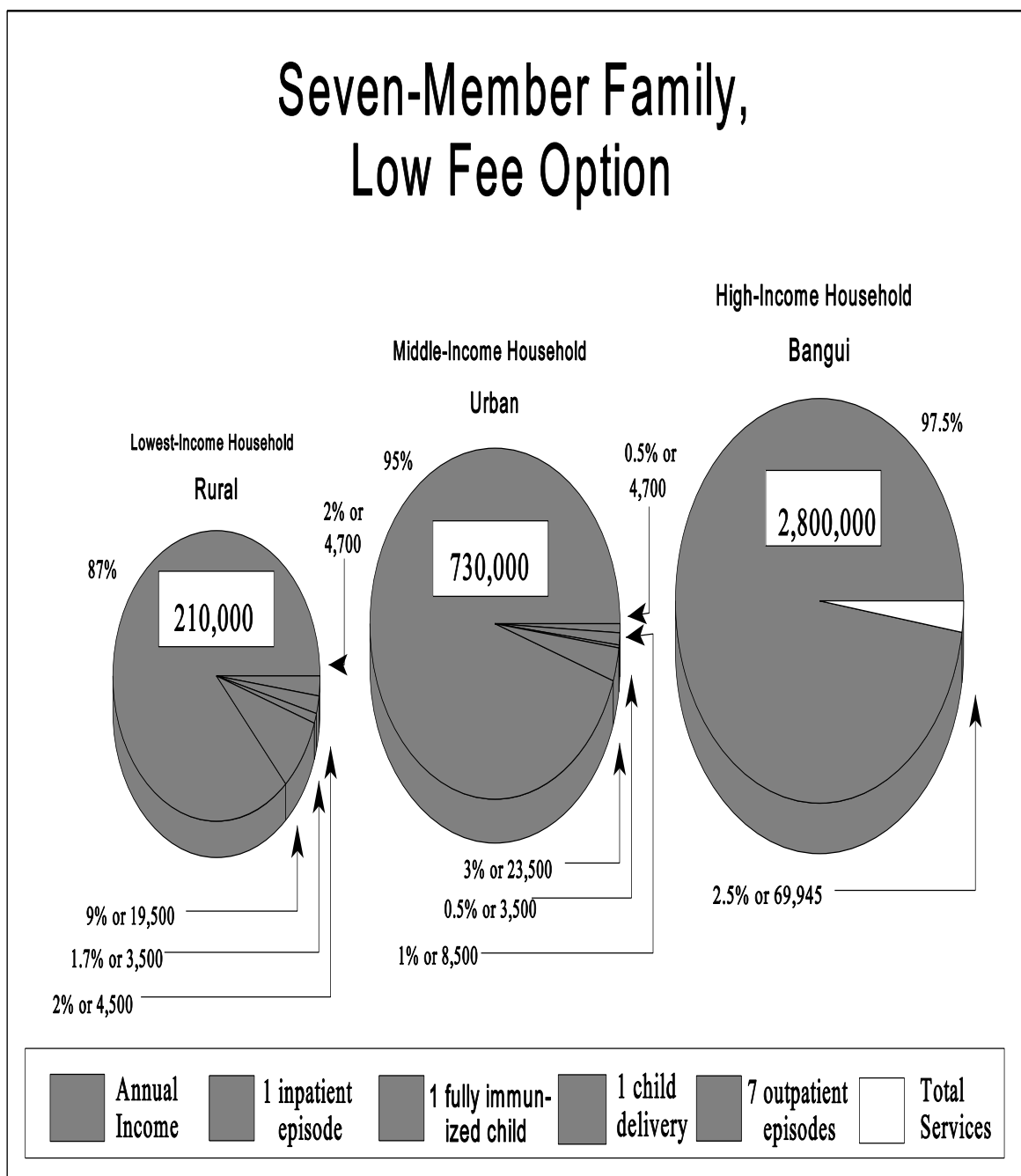
6.2.3 Total Annual Household Costs

Exhibits A.3 and A.4 in Appendix A and *Exhibit 6.3* show the total annual impact on household income of seven outpatient illness episodes and two inpatient hospital events: one childbirth and one surgery or general medicine episode. (Since fees under this proposal would be no different for inpatient surgery than for general medicine, it does not matter much for this illustrative purpose the cause of the hospital admission.) For the inpatient hospital events, the estimates assume that the lowest-income household would stay in a ward room, the middle-income household in a semi-private room, and the high-income household in a private room.

As these estimates show, the lowest-income rural household would spend, under the low- option fee, 11 percent of its income for inpatient care and a total of 13.6 percent when outpatient care is included. These households would spend 19 percent of their income under the high-option fee for all inpatient and outpatient care. In the “worst” case, costs of immunizing the child born that year would also fall in the same 12-month period, adding an additional cost of about 3,500 CFAF under the proposed fees, which represents an additional 1.7 percent of annual household income.

Of the illustrative inpatient spending, a hospital stay for general surgery or medicine would represent a much higher cost burden than a hospital stay for childbirth. For example, the low fee option for a childbirth would represent 2 percent of annual income for the lowest-income households, while an inpatient stay for either general medicine or surgery would represent 9 percent. Thus, the total under the low-option fee for the seven outpatient visits plus one hospital stay for a childbirth would represent only 4 percent of the annual income of the lowest-income household, with an additional 1.7 percent of income for a full series of immunizations for the child, if these were required that same year. Under the high-option fees, this total would rise to 7.5 percent and 9.2 percent, respectively.

Exhibit 6.3 Household Impact of Proposed Fees



For middle-income urban families, these estimates show that the total impact of two inpatient hospital stays and all outpatient health spending would represent 5 percent of annual household income under the low-option fees and 6.6 percent under the high-option. For upper-income Bangui households, the total costs would represent 2.5 percent of annual income under the low-option fees and 3.2 percent under the high option. These totals are only somewhat higher than estimates of current annual spending for outpatient care alone.

6.2.4 Overall Impact on Ability to Pay

In general, this analysis suggests that the proposed fees under both the low and high options are affordable for most of the population, especially for middle- and upper-income households. Only those households with annual incomes of 210,000 CFAF would have difficulty in paying, and then only if they had one hospital episode in addition to a childbirth in a given year. It is important to note that the financial impact on lowest-income households of the outpatient and inpatient hospital events used in this illustration would be much stronger under the current Decret 91.065 system. As indicated above, the total costs for typical inpatient hospital stays are lower under the proposed low-option fees than under the current system, especially in the case of surgery and general medicine.

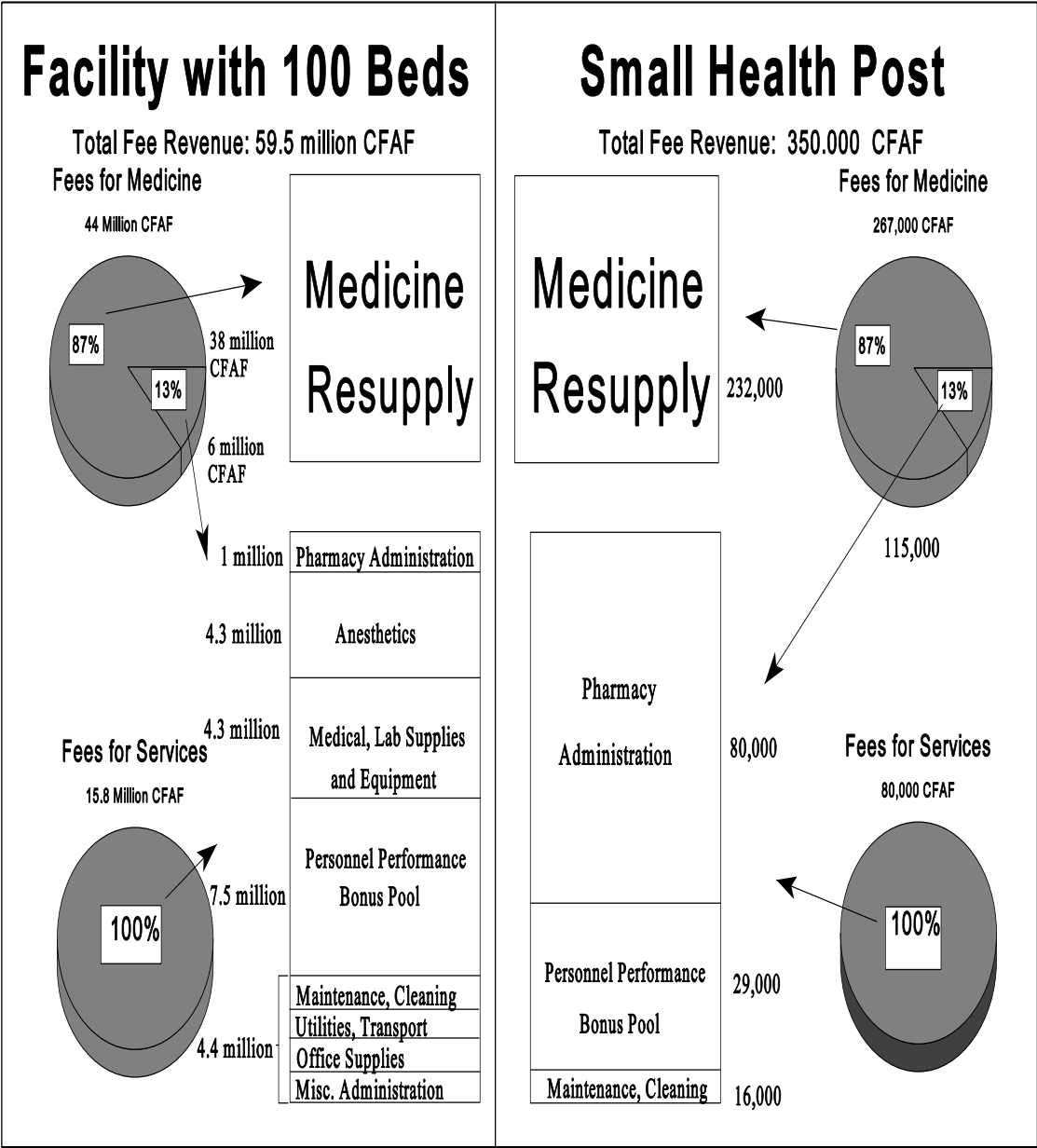
6.3 RELATIONSHIP OF REVENUES TO COST AND QUALITY IMPROVEMENTS

There currently is no systematic cost data for health facilities in the CAR, although limited cost data is available from the budgets for Bangui hospitals. In virtually all cases, expenditures in health facilities for nonsalary items are based on the funds available rather than on the costs of providing adequate or high quality care. Therefore it is impossible to establish fee prices and target revenues that correspond to accurate cost estimates for a given quantity and quality of services. It is possible, however, to evaluate whether estimated revenues will yield funds that are adequate for typical nonsalary recurrent costs and for some degree of quality improvement.

The HFS team adopted the following approach to make this assessment. In the detailed revenue and cost estimates included in the proposal, the HFS team estimated the expected annual fee revenues under both the low and high fee options for health facilities of various sizes that serve small, medium, and large population bases, assuming certain typical utilization rates. For outpatient care, the estimates assume one outpatient visit per year per person, 80 percent of which would require a medicine prescription. For inpatient care, the estimates assume 60 percent occupancy rates. The team then distributed the revenues produced by these utilization rates according to the illustrative percentages in *Exhibit 5.1*.

Exhibit 6.4 provides an example of the estimated funds such an allocation would produce for the key nonsalary recurrent operating costs and personnel incentives for a large and a small health facility. *Exhibits A.6 and A.7 in Appendix A* summarize the detailed estimates.

Exhibit 6.4 Use of Annual Fee Revenues, Low Fee Options



6.3.1 Health Facilities Outside Bangui

As shown in *Exhibit 6.4 and Exhibits A.6 and A.7*, for health facilities outside Bangui, total estimated annual revenue from inpatient and outpatient services and medicines ranges from about 60 million CFAF for the largest facilities to 30 million CFAF for medium-size facilities, and 8 million CFAF for the smallest facilities with beds. Estimated total annual revenues for a health post serving a population of 1,000 are about 350,000 CFAF. In all cases, fee revenues are adequate under both the high and low options to provide for total medicine resupply costs with a balance left over for pharmacy administration, personnel performance bonuses, and quality improvements.

For example, the balance of revenues remaining after medicine resupply ranges from about 21.5 million CFAF for a facility with 100 beds to 8 million CFAF for a small facility with 10 beds under the low fee option, and from about 75 million CFAF to 11 million CFAF under the high option. If 35 percent of the funds available after resupply of medicines were allocated to a personnel performance bonus pool, the low option would provide an estimated 7.5 million CFAF annually to distribute as bonuses to personnel for the largest facilities, 3.8 million CFAF for medium-size facilities, and 1 million CFAF for smaller facilities.

On a monthly basis, estimated fee revenues under the low option would provide a 100-bed facility with approximately 629,000 CFAF for personnel bonuses and 1 million CFAF for pharmacy administration, medical gas and supplies, facility maintenance, and other operating costs. For a facility with 10 beds, fee revenues under the low option (after medicine resupply) would provide an estimated 85,000 CFAF per month for personnel bonuses and approximately 160,000 CFAF for operating costs.

The proposed high option fees would produce 75 percent more revenue after medicine resupply for the facilities with inpatient capacity.

Health posts would have much lower fee revenues because they offer no inpatient services. A health post serving a population of 1,000 would have a balance of about 115,000 CFAF annually after medicine resupply under the low fee option and 435,000 CFAF under the high option. Because revenues would be lower at health posts, a higher percentage of the revenue remaining after medicine resupply (70 percent) would be needed to cover a small salary for a pharmacy manager, leaving about 25 percent for personnel bonuses and 5 percent for other purposes such as facility maintenance and cleaning.

Using this illustrative allocation for health posts, the low-option fees would provide about 80,200 CFAF per year (6,700 CFAF per month) for the pharmacy manager, about 28,700 CFAF annually (2,400 CFAF per month) for personnel bonuses, and 5,700 CFAF (480 CFAF per month) for facility maintenance. A medium-fee option for pharmacy service (250 CFAF) would produce about twice as much revenue as the low-option fee (100 CFAF). The high option pharmacy service fee (500 CFAF) would provide health posts with about four times as much revenue after medicine resupply than the low-option fee.

Estimates of the funds that health facilities currently receive from the MOH budget are unavailable, but it is likely that these estimated revenues would provide these facilities with substantially

more funds for operating costs, even under the low fee option. These amounts also are adequate, even under the low option, to make quality improvements and to reward personnel.

If utilization were only half the level estimated by the HFS team and estimated revenues were therefore cut in half, the low-option fees would leave facilities more constrained, especially smaller facilities with 10 beds or less. However, even under lower utilization assumptions, total fee revenue available after medicine resupply would remain adequate to make modest quality improvements (e.g., in the availability of medical supplies), although the allocation of revenues between operating costs and personnel bonuses may need to be shifted. Nevertheless, it is likely that once medicines were available, along with other medical supplies and quality improvements, utilization would reach the levels assumed in these estimates, especially for outpatient services.

6.3.2 Bangui Hospitals

Exhibits A.8 and A.9 in Appendix A show the estimated revenue under the low and high option fees at a Bangui hospital using University Hospital of Bangui as an example. They also provide an illustrative distribution of that revenue. As shown, University Hospital of Bangui would receive an estimated 450 million CFAF annually under the low option and 523 million CFAF under the high option. These revenues are adequate to cover total medicine resupply costs and to leave a balance of approximately 251 million CFAF under the low fee option and 325 million under the high option for other uses.

These revenues exceed the amount included in the 1990 MOH budget (210 million CFAF) for the University Hospital of Bangui to cover all nonsalary operating costs—even under low-option fees. Estimated revenues from low-option fees are slightly higher than the estimate by the Health Economics Unit of fee revenues for the University Hospital of Bangui (239 million CFAF) under the current Decret 91.065. The proposed high option fees would produce much higher revenues than under Decret 91.065. These higher revenues are possible even though the proposed fees under both the low and high options would produce generally lower patient costs for services at the University Hospital of Bangui.

6.3.3 Overall Impact on Revenues and Quality Improvements

Health facilities would receive enough revenues under both the low and high option fees to cover all medicine costs and to have a balance left over to improve service delivery and provide personnel performance bonuses. Under the modest utilization assumptions used here, even the low- option fees would provide revenues for notable improvements over the status quo. A possible exception is that health posts serving small population bases may not have adequate fee revenues under the low option to make necessary improvements and provide personnel incentives.

7.0 COMPARISON OF PROPOSED HOSPITAL FEE STRUCTURE WITH THE CURRENT SYSTEM

The fee structure for hospital inpatient and outpatient services proposed here represents an alternative to the system currently in effect under Decret 91.065. The current system charges fees for individual medical acts and procedures for outpatient services, with fees based on the *lettre clef* system, while inpatients pay only a daily bed fee. Medicines, when available, are provided free of charge to inpatients, while outpatients generally receive only a prescription that they fill at an outside pharmacy at their own expense.

The alternative proposed here eliminates, with two exceptions (minor outpatient surgery and childbirth), any separate fees for medical procedures and introduces a fee for medicines. It also would establish a higher fee for services at Bangui hospitals than for services at hospitals outside Bangui, on the assumption that Bangui hospitals offer a higher level of care.

This alternative has several advantages over the current system of charging separately for acts and procedures under the *lettre clef* system. First, this alternative is more closely related to the current goal of cost recovery in the CAR: to recover costs of medicines and other nonsalary operating requirements. This alternative is better adapted to a system in which health personnel are paid salaries that reflect their level of specialty. A salary and personnel bonus system can avoid the need for a system that charges for personnel services and relates those services to a coefficient to measure complexity.

Second, this proposed structure is better adapted to the current administrative capacity of Bangui and provincial hospitals. Current record keeping systems at Bangui hospitals, especially the University Hospital of Bangui, do not appear adequate to support a *lettre clef* fee system that is based on cost. The current value for each of the “*lettres*” that designate acts and procedures, such as surgery or laboratory tests, is clearly not based on the cost of performing those services, and the detailed utilization data required to do so do not appear to exist. Bangui hospitals might well use *lettre clef* systems in several years to take account of complexity for purposes of cost allocation, but the current situation appears inadequate to support or justify such a system for the cost recovery program at this time. The *lettre clef* designations could continue to be used for other purposes such as quality control or resource allocation.

Third, the alternative structure spreads the costs of illness across all patients, rather than forcing sicker patients to pay more than those that are less sick. In the absence of widespread health insurance coverage, this feature serves as a way to pool risks and to minimize the financial consequences of costly hospitalization episodes of individuals.

Fourth, it is likely that patients would find the proposed system easier to understand and more predictable. It also would be easier for hospital personnel to administer because it involves a uniform structure that applies to all inpatient care at hospitals and health centers nationwide.

8.0 EXONERATION SYSTEM AND SUBSIDIES

8.1 INDIGENTS

As noted above, the proposed fees are likely to present a problem for the lowest-income households only when family members require hospitalization for other than childbirth. Such cases will not arise for all low-income households every year. It is expected that cases in which an individual is unable to pay for outpatient medicines will be rare.

Following advice provided by numerous people interviewed in November and December 1993, the HFS team recommends that no additional steps be taken by the central MOH to establish a formal system of exoneration. Local communities can continue to take care of indigents informally as the need arises. The current system for social assistance can continue to operate to pay the costs of hospitalization for cases of extreme need. In all cases, the required fees should be paid to the facility on behalf of the indigent, whether by the local community, by a friend or neighbor, or by the local government that provides the social assistance.

Over the longer run, the MOH could provide new criteria for cases of “medical indigence,” based on options that can be discussed by the work group. The MOH also should establish a monitoring system to identify whether there is a need for a more formal system of exemption for hospitalizations.

8.2 SUBSIDIES

The HFS team recommends that the current subsidy for civil servants be eliminated or reduced because this group is among those most able to pay for health care. This analysis has shown that not only are they more than able to pay outpatient services and medicines, they also are able to pay for hospitalizations, especially since hospitalizations do not occur every year. Current law provides that the government pay for 80 percent of the fees currently charged for health services for civil servants and their families. Civil servants are to pay the remaining 20 percent of the fee at the time of treatment, while the facility receives reimbursement directly from the government.

In addition, funds saved by reducing this subsidy could be used to provide assistance to indigents. Utilization statistics indicate that in 1990 civil servants comprised about 30 percent of the inpatients at Bangui hospitals and that about 20 percent of inpatients in 1993 were unable to pay. These data mean that a hospital could lose almost 50 percent of its potential revenue if the MOH is unable to pay the civil servants’ subsidy and if indigents do not pay their fees. The amount now authorized to pay for civil servants’ health care would be more than enough to cover the hospitalization fees for those people who are unable to pay.

9.0 IMPLEMENTATION PLAN

This proposal has raised several important implementation issues, including:

- ▲ the paramount need to have in place a system for the purchase and distribution of medicine at the time the new cost recovery system is introduced;
- ▲ the need to establish a means to identify the costs of desired quality improvements in health facilities;
- ▲ the need to plan for a limited system of exoneration for the future;
- ▲ the need to develop a system for monitoring the impact of the cost recovery system; and
- ▲ the need to pay health worker salaries regularly.

In addition, the work group will need to discuss plans for informing health workers and the public about the new system, for training health workers, and for financial management systems to operate the new system.

Finally, the work group also will need to discuss how to phase the implementation process and in what areas localities should be given flexibility in implementing the national standards. The phased implementation plan should take into account that the fees adopted at the start of the program can and should be evaluated after the first year and modified as necessary.

APPENDIX A
THE PROPOSED FEE AND PRICE STRUCTURE

EXHIBIT A.1 PROPOSED FEE STRUCTURE AND PRICES: LOW-FEE OPTION					
HEALTH FACILITIES					
	HOSPITALS		HEALTH CENTERS		HEALTH POSTS
	Bangui	Outside Bangui	A&B	C&D	
OUTPATIENT SERVICES					
Medicines, Vaccines	Fee set to recover full cost, plus small margin; varies by medicine				
Consultations					
Specialist, Professor	1,000	500	500	NA	NA
Generalist	500	250	250	250	NA
TSS	250	100	100	100	NA
Pharmacy Service Fee	NA	NA	NA	NA	100
Minor Surgery	1,000	500	500	500	500
INPATIENT SERVICES					
Medicines	Fee set to recover full cost, plus small margin; varies by medicine				
Child Delivery	1,000	500	500	500	NA
Bed and Care per Day for Surgery, OB/GYN, General Medicine:					
Ward	1,500	500	500	500	NA
Semi-Private Room	2,500	1,000	1,000	NA	NA
Private Room	3,000	1,500	1,500	NA	NA
NA = Not applicable					

EXHIBIT A.2 PROPOSED FEE STRUCTURE AND PRICES: HIGH-FEE OPTION					
HEALTH FACILITIES					
	HOSPITALS		HEALTH CENTERS		HEALTH POSTS
	Bangui	Outside Bangui	A&B	C&D	
OUTPATIENT SERVICES					
Medicines, Vaccines	Fee set to recover full cost, plus small margin; varies by medicine				
Consultations					
Specialist, Professor	1,500	800	800	NA	NA
Generalist	1,000	500	500	500	NA
TSS	500	250	250	250	NA
Pharmacy Service Fee	NA	NA	NA	NA	500
Minor Surgery	1,500	800	800	800	800
INPATIENT SERVICES					
Medicines	Fee set to recover full cost, plus small margin; varies by medicine				
Child Delivery	1,500	800	800	800	NA
Bed and Care per Day for Surgery, OB/GYN, General Medicine:					
Ward	2,000	1,000	1,000	1,000	NA
Semi-Private Room	3,000	1,500	1,500	NA	NA
Private Room	4,000	2,000	2,000	NA	NA
NA = Not applicable					

EXHIBIT A.3 ILLUSTRATIVE IMPACT OF PROPOSED FEES ON ANNUAL HOUSEHOLD HEALTH SPENDING AND INCOME: LOW-FEE OPTION			
HOUSEHOLD SIZE = 7	LOW-INCOME HOUSEHOLD Rural: Lowest-Income Quintile	MIDDLE-INCOME HOUSEHOLD Non-Bangui, Urban: Middle-Income Quintile	HIGH-INCOME HOUSEHOLD Bangui: Highest- Income Quintile
ANNUAL HOUSEHOLD INCOME (CFAF)	211,496	729,708	2,798,049
HEALTH EXPENDITURES			
OUTPATIENT/1			
Medicines for 7 episodes (CFAF)	4,032	4,032	4,032
Service fee per 7 visits (CFAF)	700	700	700
TOTAL OUTPATIENT COST (CFAF)	4,732	4,732	4,732
Percent of Income	2.24	0.65	0.17
INPATIENT/2			
Surgery or General Medicine (CFAF)	19,500	23,500	40,000
Child Delivery (CFAF)	4,500	8,500	25,000
TOTAL INPATIENT COST (CFAF)	24,000	32,000	65,000
Percent of Income	11.35	4.39	2.32
TOTAL HEALTH EXPENDITURES	28,732	36,732	69,732
Percent of Income	13.59	5.03	2.49
<p><i>Source:</i> Income data from 1992 household survey conducted by MOH/Health Economics Unit</p> <p>Notes: 1) Assume episode of a common illness for each family member and one visit for each of those episodes. 2) Assume one family member has a hospital stay for either surgery or a general medical problem and one family member has a child birth. Assume low-income household stays in ward, middle-income household stays in semi-private, and high-income in private room. Low- and middle-income households pay non-Bangui fees; high-income households pay Bangui fees. Total cost for inpatient stay includes diagnostic consultation prior to admission, medicines during hospital stay, and the daily inpatient fee.</p>			

EXHIBIT A.4 ILLUSTRATIVE IMPACT OF PROPOSED FEES ON ANNUAL HOUSEHOLD HEALTH SPENDING AND INCOME: HIGH-FEE OPTION			
HOUSEHOLD SIZE = 7	LOW-INCOME HOUSEHOLD Rural: Lowest-Income Quintile	MIDDLE-INCOME HOUSEHOLD Non-Bangui, Urban Middle-Income Quintile	HIGH-INCOME HOUSEHOLD Bangui: Highest- Income Quintile
ANNUAL HOUSEHOLD INCOME (CFAF)	211,496	729,708	2,798,049
HEALTH EXPENDITURES			
OUTPATIENT/1			
Medicines for 7 episodes (CFAF)	4,032	4,032	4,032
Service fee per 7 visits (CFAF)	3,500	3,500	3,500
TOTAL OUTPATIENT COST (CFAF)	7,532	7,532	7,532
Percent of Income	3.56	1.03	0.27
INPATIENT/2			
Surgery or General Medicine (CFAF)	23,800	27,800	48,500
Child Delivery (CFAF)	8,800	12,800	33,500
TOTAL INPATIENT COST (CFAF)	32,600	40,600	82,000
Percent of Income	15.41	5.56	2.93
TOTAL HEALTH EXPENDITURES	40,132	48,132	89,532
Percent of Income	18.96	6.60	3.20
<p><i>Source:</i> Income data from 1992 household survey conducted by MOH/Health Economics Unit.</p> <p>Notes: 1) Assume episode of a common illness for each family member and one visit for each of those episodes. 2) Assume one family member has a hospital stay for either surgery or a general medical problem and one family member has a child birth. Assume low-income household stays in ward, middle-income household stays in semi-private, and high-income in private room. Low- and middle-income households pay non-Bangui fees; high-income households pay Bangui fees. Total cost for inpatient stay includes diagnostic consultation prior to admission, medicines during hospital stay, and the daily inpatient fee.</p>			

EXHIBIT A.5 COMPARISON OF HOUSEHOLD COST FOR TYPICAL HOSPITAL STAY IN BANGUI UNDER DECRET 91 AND UNDER THE PROPOSED FEE STRUCTURE			
8-DAY HOSPITALIZATION IN A WARD ROOM	Decret 91	Low Option	High Option
SURGERY AND SPECIALIZED SERVICES			
Consultations for Diagnosis	2,000	1,000	1,500
Medicines	15,000*	15,000	15,000
Acts and Procedures	32,000	0	0
Inpatient Stay (Ward, 8 days)	8,000	12,000	16,000
TOTAL	57,000	28,000	32,500
GENERAL MEDICINE			
Consultations for Diagnosis	1,000	1,000	1,500
Medicines	15,000*	15,000	15,000
Acts and Procedures	7,500	0	0
Inpatient Stay (Ward, 8 days)	4,000	12,000	16,000
TOTAL	27,500	28,000	32,500
NORMAL CHILD DELIVERY			
Consultations for Diagnosis	0	0	0
Medicines	0*	0	0
Acts and Procedures	5,000	1,000	1,500
Inpatient Stay (Ward, 8 days)	6,400	12,000	16,000
TOTAL	11,400	13,000	17,500
* Under Decret 91, the patient pays the medicine costs by purchasing them at an outside private pharmacy.			

EXHIBIT A.6
**ILLUSTRATIVE USE OF TOTAL ANNUAL FEE REVENUES FOR OPERATING COSTS OF HOSPITALS,
HEALTH CENTERS, AND HEALTH POSTS OUTSIDE OF BANGUI: LOW-FEE OPTION**

HEALTH FACILITIES								
	100 bed facility-10,000 population base for out-patient services		50 bed facility-5,000 population base for out- patient services		10 bed facility-5,000 population base for out- patient services		Health Post: No beds-1,000 population base for out-patient services	
	Revenues (CFAF)	Allocation (%)	Revenues (CFAF)	Allocation (%)	Revenues (CFAF)	Allocation (%)	Revenues (CFAF)	Allocation (%)
SOURCE OF FEE REVENUES								
OUTPATIENT								
Medicines	2,665,164		1,332,582		1,332,582		266,516	
Services	800,000		400,000		400,000		80,000	
INPATIENT								
Medicines	41,062,500		20,531,250		4,106,250		NA	
Services	15,004,069		7,738,813		1,778,500		NA	
TOTAL ANNUAL FEE REVENUES	59,531,732		30,002,644		7,617,332		346,516	
USE OF REVENUE								
Medicine Resupply	38,043,067	87	19,021,534	87	4,731,784	87	231,869	87
Balance after Resupply	21,488,665		10,981,111		2,885,548		114,647	
REMAINING ALLOCATIONS								
Pharmacy Administration	1,074,433	5	549,056	5	144,277	5	80,253	70
Anesthetics (Gaz Medicaux)	4,297,733	20	2,196,222	20	577,110	20	0	0
Medical, Lab Supplies and Equipment	4,297,733	20	2,196,222	20	577,110	20	0	0
Personnel Performance Bonus Pool	7,521,033	35	3,843,389	35	1,009,942	35	28,662	25
Maintenance and Cleaning	1,074,433	5	549,056	5	144,277	5	5,732	5
Office Supplies	1,074,433	5	549,056	5	144,277	5	0	0
Utilities and Transport	1,074,433	5	549,056	5	144,277	5	0	0
Miscellaneous Administrative Contingency Fund	1,074,433	5	549,056	5	144,277	5	0	0
Depreciation	0	0	0	0	0	0	0	0
TOTAL OUTLAY OF REVENUE	59,531,732		30,002,644		7,617,332		346,516	
* Facilities assumed to have a 60 percent occupancy rate. NA = Not applicable.								

TABLE A.7
ILLUSTRATIVE USE OF TOTAL ANNUAL FEE REVENUES FOR OPERATING COSTS OF HOSPITALS,
HEALTH CENTERS, AND HEALTH POSTS OUTSIDE OF BANGUI: HIGH-FEE OPTION

HEALTH FACILITIES								
	100 bed facility-10,000 population base for out-patient services		50 bed facility-5,000 population base for out-patient services		10 bed facility-5,000 population base for out- patient services		Health Post: No beds-1,000 population base for out- patient services	
	Revenues (CFAF)	Allocation (%)	Revenues (CFAF)	Allocation (%)	Revenues (CFAF)	Allocation (%)	Revenues (CFAF)	Allocation (%)
SOURCE OF FEE REVENUES								
OUTPATIENT								
Medicines	2,665,164		1,332,582		1,332,582		266,516	
Services	4,000,000		2,000,000		2,000,000		400,000	
INPATIENT								
Medicines	41,062,500		20,531,250		4,106,250		N/A	
Services	26,965,200		14,010,913		3,362,125		N/A	
TOTAL ANNUAL FEE REVENUES	74,692,864		37,874,744		10,800,957		666,516	
USE OF REVENUE								
Medicine Resupply	38,043,067	87	19,021,534	87	4,731,784	87	231,869	87
Balance after Resupply	36,649,796		18,853,211		6,069,173		434,647	
REMAINING ALLOCATIONS								
Pharmacy Administration	1,832,490	5	942,661	5	303,459	5	304,253	70
Anesthetics (Gaz Medicaux)	7,329,959	20	3,770,642	20	1,213,835	20	0	0
Medical, Lab Supplies and Equipment	7,329,959	20	3,770,642	20	1,213,835	20	0	0
Personnel Performance Bonus Pool	12,827,429	35	6,598,624	35	2,124,211	35	108,662	25
Maintenance and Cleaning	1,832,490	5	942,661	5	303,459	5	21,732	5
Office Supplies	1,832,490	5	942,661	5	303,459	5	0	0
Utilities and Transport	1,832,490	5	942,661	5	303,459	5	0	0
Miscellaneous Administrative Contingency Fund	1,832,490	5	942,661	5	303,459	5	0	0
Depreciation	0	0	0	0	0	0	0	0
TOTAL OUTLAY OF REVENUE	74,692,864		37,874,744		10,800,957		666,516	
* Facilities assumed to have a 60 percent occupancy rate.								

EXHIBIT A.8
BANGUI HOSPITAL FEES AND ESTIMATED ANNUAL REVENUES UNDER LOW- AND HIGH-FEE OPTIONS:
UNIVERSITY HOSPITAL OF BANGUI
(amounts in CFAF)

FEE CATEGORIES	LOW-FEE OPTION		HIGH-FEE OPTION	
	FEES	REVENUES	FEES	REVENUES
A. MEDICINES				
1) Outpatient Medicine Mark-Up Rate, Total Revenue	300% over price of origin	5,412,614	300% over price of origin	5,412,614
Amount to Cover Replacement Cost	87% of final price	4,708,974	87% of final price	4,708,974
Subtotal Outpatient Revenue to Facility	13% of final price	703,640	13% of final price	703,640
2) Inpatient Medicine Mark-Up Rate, Total Revenue	300% over price of origin	221,625,000	300% over price of origin	221,625,000
Amount to Cover Replacement Cost	87% of final price	192,813,750	87% of final price	192,813,750
Subtotal Inpatient Revenue to Facility	13% of final price	28,811,250	13% of final price	28,811,250
3) NET MEDICINES REVENUE TO FACILITY	13% of final price	29,514,890	13% of final price	29,514,890
B. SERVICES				
1) OUTPATIENT AND ADMISSION CONSULTATIONS				
Specialist, Professor	1,000	4,061,750	1,500	6,092,625
Generalist	500	4,061,750	1,000	8,123,500
TSS	250	1,015,438	500	2,030,875
SUBTOTAL		9,138,938		16,247,000
2) ACTS AND PROCEDURES				
Minor Outpatient Surgery	1,000	8,370,000	1,500	12,555,000
Child Delivery	1,000	2,723,000	1,500	4,084,500
SUBTOTAL		11,093,000		16,639,500
3) INPATIENT CARE (SURGERY,OB/GYN, GENERAL MEDICINE)				
Private Room/Day	3,000	17,518,500	4,000	23,358,000
Semi-Private Room/Day	2,500	43,796,250	3,000	52,555,500
Ward/Day	1,500	140,148,000	2,000	186,864,000
SUBTOTAL		201,462,750		262,777,500
TOTAL SERVICES REVENUES		221,694,688		295,664,000
TOTAL REVENUES		448,732,301		522,701,614
OPERATING COSTS TO BE RECOVERED BY FEE REVENUES				
Nonsalary, Non-Medicine Expenditures (1990)		210,000,000		210,000,000

TABLE A.9
ILLUSTRATIVE USE OF ANNUAL FEE REVENUES FOR OPERATING COSTS OF BANGUI HOSPITALS:
UNIVERSITY HOSPITAL OF BANGUI UNDER LOW- AND HIGH-FEE OPTIONS

ITEMS	LOW-FEE OPTION		HIGH-FEE OPTION	
	REVENUES (CFAF)	ALLOCATION (%)	REVENUES (CFAF)	ALLOCATION (%)
SOURCES OF FEE REVENUE				
Total Medicines	227,037,614		227,037,614	
Total Services	221,694,688		295,664,000	
TOTAL ANNUAL FEE REVENUE	448,732,301		522,701,614	
USE OF REVENUE				
Medicine Resupply	197,522,724	87	197,522,724	87
BALANCE AFTER RESUPPLY	251,209,577		325,178,890	
ALLOCATION OF BALANCE				
Pharmacy Administration, Salaries	12,560,479	5	16,258,944	5
Aesthetics (Gaz Medicaux)	50,241,915	20	65,035,778	20
Medical, Lab Supplies, and Equipment	50,241,915	20	65,035,778	20
Personnel Performance Bonus Pool	87,923,352	35	113,812,611	35
Maintenance, Cleaning	12,560,479	5	16,258,944	5
Office Supplies	12,560,479	5	16,258,944	5
Utilities, Transport	12,560,479	5	16,258,944	5
Miscellaneous Administrative Contingency Fund	12,560,479	5	16,258,944	5
Depreciation	0	0	0	0
TOTAL OUTLAY OF REVENUE	448,732,301		522,701,614	

APPENDIX B
MODIFICATIONS TO PROPOSED FEE STRUCTURE

SUMMARY PROCEEDINGS OF THE WORKSHOP APRIL 5-9, 1994

The Ministry of Health and Population (MOH) of the Central African Republic (CAR) asked the Health Financing and Sustainability (HFS) Project to develop a proposed comprehensive fee structure for a national program of cost recovery for government health services and to send a team to Bangui to prepare and participate in a workshop to make decisions on the fee structure and related implementation policies. The workshop was held April 5-9, 1994, and marked the culmination of seven years of health financing assistance to the CAR from the U.S. Agency for International Development (USAID) and four years of assistance from the HFS Project.

HFS designed the workshop in two phases. The first phase, held April 5-7, 1994, was a three-day session with a small work group of senior staff from the MOH and the Ministry of Finance. This small group session offered participants an opportunity to engage in extensive and informal discussion and to develop a proposal in which they had confidence, using as a starting point the HFS proposal outlined in the body of this report.

The objectives of the workshop were to:

- ▲ Achieve consensus on final policies for a comprehensive plan of nationwide cost recovery for MOH health services;
- ▲ Make recommendations to the Minister of Health on a fee structure for all levels of the system, on specific prices, on use of revenues collected from fees, and on government budget funding for health; and
- ▲ Identify the main components of phased implementation of the new plan to begin in June 1994.

Participants in the small group readily reached a consensus on the overall fee structure as proposed, with several changes in the details. The group was as concerned about the revenue potential and incentives for health worker performance under the proposed system as about patients' ability to pay. The general effect of the changes offered by the small group was to choose fee levels that were higher than in the HFS proposal, but that were nevertheless within the range of the population's ability and willingness to pay for health services, as gauged by available evidence.

The second phase of the workshop, held April 8-9, 1994, brought together 40 people representing the MOH and other government ministries, the Office of the President, the Parliament, and bilateral and multilateral donors. At this larger group session, the MOH work group presented its detailed recommendations on a comprehensive cost recovery program and responded to questions. The larger group suggested modifications and reached a broad consensus on the recommendations to be forwarded to the Minister of Health. The group also identified areas of debate about which the minister and other government officials should be aware in making final policy decisions.

The participants reached consensus on establishing a fee structure and prices that range from full cost recovery for medicines to partial cost recovery for consultation and hospital inpatient services. The recommendations covered fees for all inpatient and outpatient medicines and contraceptives, a consultation surcharge to cover the cost of vaccines, outpatient consultations and minor surgery, inpatient hospital stays, child delivery, and laboratory and X-ray services at national facilities. The workshop also reached agreement on the use of fee revenues for restocking medicines, for the purchase of other needed medical supplies and quality improvements, and to provide incentives for personnel performance.

Participants also made decisions about the broad outlines of a phased implementation strategy that included immediate priorities for establishing a mechanism for purchasing and distributing essential generic drugs so that they would be available at all MOH health facilities. The implementation strategy also included drafting and approval of implementing regulations; conducting an information campaign for health personnel, public and private organizations, and the general population; and developing needed supervision, monitoring, training, and financial management systems.

Workshop participants also debated reducing government subsidies for civil servants' health costs, applying a cap for "catastrophic" medical expenses, and using existing informal and governmental systems to assist indigents. The areas of discussion that generated the most controversy included alternative methods of paying for vaccines, contraceptives, inpatient hospital services, and the care of indigents. In addition, participants held an extended discussion about phasing the implementation—specifically whether the comprehensive new policies should be started in Bangui, outside Bangui, or simultaneously in all parts of the country.

The proceedings of the larger workshop were broadcast on national radio and television. On the last day of the large group session, a personal representative of President Patasse made a speech in which he assured participants of the government's support of the goals of cost recovery. He reminded participants that President Patassé had been minister of health during the 1970s, that he maintained a strong interest in the country's health services, that he had been highly critical of the corruption that occurred under the national health card system introduced and subsequently dropped in the mid-1970s, and that he believed a major flaw of the national health card system had been that the funds from the sale of the card had been returned to the Treasury and not used to improve services at the health facilities. He stated emphatically that President Patassé would not allow diversion of fee revenues, that cost recovery would be successful only if carried out independently of the national Treasury, and that fee revenues must remain at the facility level to be used to improve service delivery.

HIGHLIGHTS OF THE WORKSHOP DECISIONS

Preconditions for Implementation

The small group identified the following preconditions required for the implementation of a national cost recovery program:

- ▲ Make essential drugs in generic form available to all government health facilities;
- ▲ Pay government salaries regularly;
- ▲ Grant partial financial autonomy to health facilities to enable them to keep the fee revenues they collect and decide how to spend the fee revenue;
- ▲ Maintain government health budget at the current level; and
- ▲ Grant duty-free import of generic drugs.

The larger group readily agreed that this was a minimal list of preconditions necessary for the success of cost recovery in the CAR.

Medicines, Vaccines, Contraceptives

The HFS proposal recommended that patients pay the full cost of all inpatient and outpatient medicines at all levels of the health system. The proposal also recommended paying fees for vaccines and for contraceptives.

The proposal suggested that medicine fees be set at a price equal to three times the purchase price at the point of origin. Based on current operating experience in the CAR, this formula could be expected to cover all costs related to medicine purchase, transport, and distribution, and would provide a small margin (13 percent of the final sale price) to generate operating revenues for the facilities. In order to keep the fee for vaccinations at a minimum, the proposal recommended the same formula for vaccine charges as for other pharmaceuticals, without an additional charge for the cold chain costs associated with vaccine transport and storage. The final prices to patients would reflect a modest amount of internal cross-subsidization, under which the least expensive pharmaceuticals and contraceptives would be sold at higher prices to enable the more expensive ones to be sold at or below original purchase price.

The proposal recommended uniform medicine fees throughout the country. That is, each medicine would have its own specific price related to its original cost, but each of those specific fees would be the same everywhere in the country.

Modifications and Decisions

The small work group adopted the proposal for medicines, vaccines, and contraceptives without change. They clarified that the medicines made available through the public health system would be essential generic drugs as classified in the international code. They discussed the possible impact of fees for vaccines on vaccination coverage and rates and concluded that the proposed fees would not inhibit utilization, based on 1) recent experience showing that people sought and paid for immunization from the private sector when vaccines

were not available in the public sector, and 2) evidence a recent from household survey in the CAR about willingness to pay for immunizations.

The larger group made one major change to the medicine proposal: Vaccines are to remain free of charge and an unspecified increase would be added to the proposed outpatient consultation fees to cover vaccine costs. The larger group almost adopted a similar amendment for contraceptives, but agreed instead to charge fees, with a specific requirement that the final prices for contraceptives should reflect an internal cross-subsidization to lower the fee for the most expensive methods.

A representative from UNICEF and some MOH personnel strongly resisted the proposal to charge for vaccines. The UNICEF representative expressed strong concern that fees for immunization would reduce utilization and prevent the CAR from reaching immunization coverage goals. The responses of the MOH to this concern first emphasized findings and widespread evidence from recent surveys and from recent utilization experience that people in the CAR are willing to pay for immunizations. Second, they emphasized the desire and need to reduce dependence on donor funding for vaccines, citing recent evidence of reductions in that funding and absence of vaccines. Nevertheless, after lengthy discussion the group appeared to reach a consensus to adopt the UNICEF representative's modification.

The larger group also engaged in lengthy discussion about whether to charge for drugs for chronic illnesses such as tuberculosis and leprosy. No consensus could be reached on this subject; part of the group strongly favored free distribution of these medicines for public health reasons, and part of the group favored patient payment.

Outpatient Consultations

The HFS proposal recommended that all patients pay either a pharmacy service fee (at health posts) or a consultation fee for each visit (at all other health facilities), with the specific price varying according to the level of care based on the type of facility and health personnel delivering the service. When minor outpatient surgery is needed, patients would pay a fee for the outpatient surgery instead of the consultation fee. Laboratory tests and X-ray exams would be provided free of charge if required as part of a consultation. Patients would pay for medicines separately from the consultation or pharmacy service fee levels of the health system.

Modifications and Decisions

The small group made three changes to the proposal for outpatient consultations. Outpatients would pay a separate fee for laboratory tests and exams performed at facilities in Bangui such as the National Laboratory for Blood Transfusion and the National Laboratory for Sexually Transmittable Diseases. They made this decision to be consistent with the current legislative requirements for these centers to be financially autonomous.

In addition, the small group changed the pharmacy fee at the health post level to a consultation fee and thus made a fee applicable to all visits, regardless of whether or not medicines were prescribed. The small group also agreed that pre- and post-natal visits would be paid as regular consultations. They concluded that the price they had agreed on for the consultation fee would not be high enough to discourage these visits.

Finally, the small group decided that patients requiring outpatient surgery would pay the minor surgery fee *in addition to*, rather than instead of, an outpatient consultation fee. They made this decision since two actions would be involved—i.e., a consultation would occur first, independent of the minor surgery—and to ensure additional revenue for the facility.

The larger group made two further amendments. First, rather than pay a consultation fee for each visit, patients would pay a fee per episode of illness, which would include the first consultation and a set number of follow-up visits. The number of free follow-up visits would be based on the treatment protocol (i.e., the disease being treated).

Second, in case of patient referral from one practitioner to another in the same facility and from one facility to another, patients would pay a total fee equal to but no more than the fee charged for the highest level of practitioner. For example, under the fee structure proposed by the small group, a patient seeing a nurse practitioner (TSS) at a hospital in Bangui would pay 500 CFAF and would pay 1,000 CFAF to see a general physician. The proposal did not explicitly address referral cases. Under the large group's amendment, if the TSS referred the patient to a generalist in the hospital, the patient would pay 500 CFAF for seeing the TSS and an additional 500 CFAF to see the generalist on referral. The total amount, 1,000 CFAF, equals the fee that would have been charged had the patient originally seen the generalist. This decision reflected the larger group's concern that revenue both equal the amount set for the highest level of care received and provide recognition for the most specialized personnel's services, balanced by a concern that patients who are referred need not pay the full cost of two separate fees.

Inpatient Services

The HFS proposal recommended that all patients pay a flat daily fee for hospitalization, varying according to type of accommodation (private, semi-private, or ward room) and the level of facility care. Separate fees would not be charged for medical services and tests, but patients would pay fees for medicines. An additional flat fee would be charged for child delivery to recognize longstanding current practice that treats this service as a special procedure with a separate charge. Child delivery also is a service that households can plan for and is not an unanticipated event as are other hospital admissions.

The proposal recommended that patients pay somewhat higher inpatient fees at Bangui hospitals than at inpatient facilities outside Bangui (both hospitals and health centers with beds). Bangui hospital fees would be higher in recognition of their status as referral centers and their higher level of care. Under the same principal, fees at all hospitals and health centers outside Bangui would be the same on the assumption that, at present, health centers and hospitals do not differ significantly in the quality of service provided.

Modifications and Decisions

The small group discussed the inpatient fee proposal at some length and made two changes. Participants readily agreed that Bangui hospital fees should be higher than inpatient fees at facilities outside Bangui. Most participants also agreed that the level of care currently given in hospitals and health centers outside Bangui does not differ sufficiently to justify a higher fee for inpatient care at non-Bangui hospitals. However, in order to maintain the principal that regional and prefectural hospitals should be referral facilities for the health centers, the group decided to charge a higher fee for inpatient stays at non-Bangui hospitals than for services at health centers outside Bangui. The small group also wanted to ensure that sufficient revenues were raised to provide adequate incentives to hospital-based personnel outside Bangui, some of whom are higher-level medical specialists.

Second, the small group decided that a maximum amount, or ceiling, should be set for hospitalization by each facility to protect the patients from high costs of an extended hospital stay due to “catastrophic illness.” They decided to set the specific ceiling later.

The large group agreed with the small group’s recommendations, but there was a lengthy discussion about the proposal to charge for hospitalization on a per illness or per diagnosis basis, with higher fees for more complex cases. No consensus could be reached and a vote was taken. A majority voted to adopt the small group’s proposal and opted for a flat daily payment, varying only according to accommodation.

The large group readily reached consensus that under either payment system patients should pay separately for medications and that fees for inpatient medicines should be set to recover their full cost.

Indigents

Following widespread advice from practitioners during an MOH–HFS field review in late 1993, the proposal recommended that no change be made in the short run to the current formal and informal systems for indigents until there was operational experience with the new cost recovery system. The proposal emphasized the recommendation that all patients should pay the required fees and that others (e.g., a relative or neighbor, or the government social assistance programs) should make the payment on behalf of indigents.

Modifications and Decisions

The small group agreed with the proposal but modified the principal of seeking payment for all indigents, especially for inpatient hospital or emergency care. The small group agreed to continue the current practice of making the doctor or health worker responsible for determining who is indigent and whose fees would be subsidized with funds from the facility’s general fee revenues. They also agreed that statistics should be kept to monitor and evaluate the percentage of patients who are determined eligible for free care.

In the larger group several participants expressed concern about people’s ability to pay fees for health services in general. Others cited the difficulties of treating homeless people and other indigents in Bangui who needed emergency care, especially hospital care, but for whom no family or community member was available to pay. Other participants maintained that those situations were exceptions, that family and communal solidarity

were widespread in the CAR, that “free care” is a colonial concept, and that exemption policies are subject to abuse.

In the end, the larger group agreed with the small group’s proposal that no formal change be made to the current system. In the short run, medical personnel in the facilities would be best equipped to make decisions about how to subsidize or receive payment for care of indigents.

Civil Servants

The proposal recommended that current subsidies for civil servants be reduced or eliminated since (as long as they receive their salaries regularly) civil servants are among those most able to pay for health services.

Modifications and Decisions

The small group modified the proposal in two ways. They decided that civil servants would pay the full fee at the time of service, as everyone else would, but would seek reimbursement for 80 percent of the fee from the government. This decision represented a compromise to reflect a desire to maintain the current law’s benefits for civil servants but to better ensure that health facilities would in fact receive full payment for the services provided. The small group thought that civil servants would be better able to influence the government to reimburse them than health facilities.

The small group also decided that an exception to the general rule that civil servants pay 100 percent of the fee at the time of service should be made for MOH employees and their families. They decided that MOH employees should not have to pay any fees for consultations and hospitalization on the grounds that employees of other public service organizations receive such services free, e.g., telephone company employees received their telephone service free. The small group did agree that MOH employees should pay for drugs. After much debate, the small group also reached consensus that all MOH employees should benefit from the payment exemption, not just those who work at the health facilities, and that the definition of “family” would be limited to spouses and children. The small group also agreed that this provision should be monitored to see how much fee revenue is lost due to this exemption.

The larger group agreed to the small group recommendations, but not before specifying that utilization by MOH employees should be tracked closely to prevent abuses and to measure the financial impact of their care on the health system.

Foreigners

Under current practice in the CAR, foreigners must pay a higher daily fee than nationals for inpatient stays at hospitals or health centers. The HFS proposal dropped this distinction, recommending that foreigners pay the same fee as nationals, since neither the services nor the accommodations were different.

Modifications and Decisions

The small group decided to maintain current practice and to charge foreigners twice the daily fee paid by nationals for inpatient stays. The larger group did not have time to discuss this provision.

Use of Revenues

The HFS proposal recommended that fee revenues be retained by the facilities, rather than transferred to the Treasury, and that revenues be used first to resupply pharmacies and maintain the medicine supply and distribution system. After resupplying medicines, the balance of the receipts would be used to pay for quality improvements, such as purchase of consumable medical supplies and equipment, establishing a bonus pool for personnel rewards for good performance, and other improvements most highly associated with patient-perceived quality of care (e.g., transport for mobile vaccination teams and facility maintenance).

Modifications and Decisions

The small group agreed with the proposal, including the provision that funds to be distributed to personnel should be pooled and distributed based on criteria that reflect individual qualifications and performance, rather than returned to the individuals who provided the service. After much discussion, they also reached consensus that non-medical personnel at the health facilities should also be included in the bonus pool. The health management committees at the health centers and posts and the management boards at the hospitals facilities would be responsible for determining criteria for allocating all the fee revenues, including the appropriate proportion for both the personnel bonus pool and the individual personnel awards. These committees also would be responsible for monitoring implementation of the cost recovery system and expenditures.

Due to time constraints, the larger group did not discuss the use of receipts.

Implementation Strategy

The HFS proposal included an outline of implementation steps and phases. It emphasized as an immediate priority the need for having a medicine purchase and distribution system in place at the time the new cost recovery system is introduced. It also recommended that the MOH implementation strategy include plans for 1) evaluation and monitoring systems to assess impact of recovery program on revenues, quality improvements, household spending, and indigents; 2) means to identify costs of desired quality improvements in health facilities; 3) future plans for a limited system of subsidies for indigents and other special cases; 4) means to permit local flexibility beyond the national standards; 5) systems for changes in fees and fee allocation based on experience; and 6) complementary efforts to pay health worker salaries regularly.

The HFS presentation to the small group also suggested numerous specific areas in which action would be necessary, such as plans for informing health workers, other government organizations, private organizations, and the public about the new system; training for health workers and management committees; and design of financial management systems and manuals for the new system.

Modifications and Decisions

The small group agreed with the proposal and elaborated the following strategy:

- ▲ Make necessary legislative and regulatory changes, giving special attention to provide all health facilities with partial financial autonomy so that they can retain and spend their fee revenues as they decide.
- ▲ Place top priority on establishing as soon as possible a well-functioning generic drug distribution system.
- ▲ Implement the cost recovery system first in health facilities that have the most experience with charging, collecting and managing fees, for example, all health facilities in Bangui and in the regions where cost recovery is in place.

The small group also identified the following steps, in no particular order of importance, that they thought would need to be undertaken simultaneously, depending on resources available:

- ▲ Conduct information (“*sensibilisation*”) campaigns targeting the general population and targeting health personnel.
- ▲ Develop supervision and monitoring indicators, and put the monitoring and supervision systems in place.
- ▲ Modify procedures and practices where cost recovery is now taking place to reflect the national system, with changes instituted gradually to strike a balance between harmonization with national policies and avoiding disruption in the operations of the health facilities.
- ▲ Establish a special working group (“*Cellule de Coordination et de Suivie*”) to work on the implementation plan and execution. This group should be composed of health ministry personnel under the guidance of an highly placed MOH official.

The larger group debated at length the small group’s recommendation to begin implementation in Bangui. Several participants argued that implementation would have to be national from the start and that the whole population was expecting and ready for cost recovery. All recognized that implementation would depend on the resources available and on what tools were available. Some participants agreed with the small group recommendations that Bangui should be targeted first, because of its proximity and easy access and existing cost recovery activities (in the hospitals and national laboratories). Others argued that implementation would have a greater chance of success in the field. No consensus could be reached.

The larger group suggested that basic management and training modules developed by UNICEF as part of the Bamako Initiative might be modified or adopted for cost recovery implementation at the health centers. There was consensus that training of personnel was a key to the success of the implementation plan.

APPENDIX C
PRESIDENTIAL DECREE REGULATING CHARGES FOR SERVICES
PROVIDED BY PUBLIC HEALTH ESTABLISHMENTS
IN THE CENTRAL AFRICAN REPUBLIC

DECREE No. 94:336

**REGULATING CHARGES FOR SERVICES PROVIDED BY
PUBLIC HEALTH ESTABLISHMENTS IN THE CENTRAL AFRICAN REPUBLIC**

THE PRESIDENT OF THE REPUBLIC AND HEAD OF STATE,

- Having regard to the Constitution of November 28, 1986, as amended by Constitutional Laws No. 91:001 and 91:003 of March 8 and July 4, 1991 and No. 92:013 of August 28, 1992;
- Having regard to Law No. 89:003 of March 29, 1989 establishing the general principles governing public health in the Central African Republic;
- Having regard to Decree No. 73:006 of March 8, 1973 containing regulations with respect to financial approval of administrative acts at the level of ministerial departments;
- Having regard to Decree No. 93:329 of October 24, 1993 containing the appointment of the Prime Minister, Head of Government;
- Having regard to Decree No. 93:349 of October 29, 1993 containing the appointments of members of the government;
- Having regard to Decree No. 94:081 of March 4, 1994 organizing the Ministry of Public Health and Population and establishing the functions and powers of the Minister;

On the proposal of the Minister of Public Health and Population,

Having consulted the Council of Ministers,

HEREBY DECREES:

TITLE I: GENERAL PROVISIONS

CHAPTER I

- Art. 1 The purpose of the present decree is to implement Articles 3, 5, 6, 7, 9 and 10 of Law No. 89:003 of March 23, 1989 establishing the general principles governing public health in the Central African Republic.
- Art. 2 Every citizen is entitled to health and shall be free to choose his own practitioner.
- Art. 3 Every citizen has an obligation to contribute financially to the different health services offered by the overall system of health establishments and services, both public and private.

- Art. 4 All public health facilities shall operate under a system of partial management autonomy.
- Art. 5 For the payment of health expenses, the practice of third-party payment shall be authorized.

TITLE II: COVERAGES

CHAPTER II: PRIVATE AND PARASTATAL COMPANIES

- Art. 6 Agreements and contracts to cover the health expenses of patients in the private or parastatal sector shall be concluded between the Ministry of Public Health and Population and private and parastatal companies.
- Art. 7 The modalities of coverage and reimbursement shall be established in a decree issued by the Minister of Public Health and Population.

CHAPTER III: CIVIL SERVANTS AND GOVERNMENT OFFICIALS

- Art. 8 Civil servants and government officials and their families (spouses and recognized minor dependent children) shall contribute 20% of their health expenses; 80% shall be covered by the State.
- Art. 9 A new budget item shall be created in the state budget to assure reimbursement of 80% of the health expenses of civil servants and government officials at public health facilities.
- Art. 10 Fees shall be charged for drugs.

CHAPTER IV: SOCIAL WELFARE RECIPIENTS

- Art. 11 Patients who are documented as receiving social welfare from the State or local authorities shall be covered.
- Art. 12 A new budget item shall be created in the budget of the State or local authorities to assure reimbursement of the health expenses of social welfare recipients at public health facilities.
- Art. 13 A decree issued by the Minister of Public Health and Population shall set the amounts and the reimbursement modalities of the counterpart.

CHAPTER V: HEALTH PERSONNEL

- Art. 14 Employees and officials of the Ministry of Public Health and Population and their families (spouses and recognized minor dependent children) shall be eligible for free consultations and hospitalization. However, they shall be required to pay for drugs.

TITLE III

CHAPTER VI: HEALTH SERVICES

Art. 15 The health services listed below shall be subject to charges:

- ▲ outpatient visits;
- ▲ hospitalization;
- ▲ surgical interventions and plaster casts;
- ▲ childbirth;
- ▲ drugs.

Art. 16 A decree issued by the Minister of Public Health and Population shall set the rates and the modalities of payment for these services.

A. OUTPATIENT CONSULTATIONS

Art. 17 Every visit shall be subject to charges. Patients shall pay according to the facility level at which they are actually examined. If they are referred to a higher level, they shall pay the difference. In the event of medical evacuation within the Central African Republic, patients shall pay the difference to the receiving health facility.

Art. 18 Pre- and post-natal examinations shall be charged at the same rate as outpatient visits.

Art. 19 Consultation shall be based on each occurrence of a disease. Follow-up visits for such occurrence shall be free of charge. The periods of validity for such follow-up visits shall be fifteen days for medical treatment and thirty days for surgery.

Art. 20 The charge for visits shall vary according to the level of specialization of the practitioner and the size of the health facility.

Art. 21 The scale of charges for the other central establishments, namely: the National Clinical Biology and Public Health Laboratory, the Referral Center for Sexually Transmittable Diseases, and the National Blood Transfusion Center, shall be set in decrees issued by the Minister of Public Health and Population.

Art. 22 The scale of charges for medical certificates shall be set as follows:

- ▲ compulsory certificate: CFAF 1,000
- ▲ special-purpose certificate: CFAF 2,000

B. HOSPITALIZATION

Art. 23 The scale of charges per day of hospitalization shall be determined by the costs of the different services provided to patients during their stay at the health facility.

Art. 24 The scale of charges per day of hospitalization shall be set according to the size of the establishment and the category of hospitalization selected.

Art. 25 Hospitalization categories shall be determined by the following criteria:

- ▲ first class: hospital room with one bed;
- ▲ second class: hospital room with two or three beds;
- ▲ third class: hospital room with four or more beds.

A decree issued by the Minister of Public Health and Population shall set the charges for hospitalization in private rooms and special suites.

C. DRUGS

Art. 26 Patients admitted for outpatient consultations or to hospital shall pay for their drugs at the health facility upon presentation of a medical prescription.

Art. 27 A decree issued by the Minister of Public Health and Population shall establish the rules governing the sale of drugs.

D. DISPOSITION OF REVENUES

Art. 28 Revenues from the sale of essential drugs shall be used preferentially to replenish the health facility's supply of essential drugs.

Art. 29 Revenues from outpatient consultations shall be used to improve the delivery of services and to pay a share to all the staff of the health facility.

Art. 30 The share may in no case exceed 30 percent (30%) of the total revenues available from outpatient consultations and care.

Art. 31 The modalities for distributing shares of revenues and the pertinent percentages shall be set by the board or management committee of the health facility.

Art. 32 The present decree, which supersedes all prior provisions that may conflict with it, notably Decree No. 091/65 of March 8, 1991, shall take effect from the date of its signature. It shall be recorded and published in the Official Gazette of the Central African Republic.

Bangui
September 29, 1994
Ange-Félix Patassé